Healthcare practitioners' and patients' perspectives of a weight management service and the place of psychological support within this.

SINDEEP K LEHL

A thesis submitted in partial fulfilment of the requirements of the University of Wolverhampton for the degree of MASTER OR DOCTOR OF PHILOSOPHY/DOCTOR IN COUNSELLING PSYCHOLOGY

22/07/16

Signature ……..

Date ……

Healthcare practitioners' and patients' perspectives of a weight management service and the place of psychological support within this.

Abstract

Both the NHS and Public Health are keen to identify how best to manage long term health condition's as a result from obesity and vice-versa. There is evidence to support the efficacy of psychological support in weight management programmes. This study explored the perceived importance of psychological support within weight management services; perspectives of both client and healthcare practitioners, in view of considering the implications for the role of a counselling psychologist.

There were nine interviews conducted with five healthcare practitioners and four clients. The professionals' disciplines included: physiologist, dietician, health psychologist, programme manager, and a medical consultant. Of the four patients, two had accessed psychology services as part of their weight management programme and two had not. Data was analysed using thematic analysis. Five overarching themes were identified. Tension (pivotal central theme) this connected to: Lifestyle; Quality of Life (QoL); Service Delivery Model; and Professional and Personal beliefs and values. The findings highlighted that perceived importance of psychological support was influenced by an individuals' background and experiences by both groups. The implications for the role of a counselling psychologist was to provide training to health professionals as well as raising clients' awareness of the role of counselling and psychological support within such programmes. Further research is needed to understand better the potential of psychological support within weight management services to help contain UK obesity.

Acknowledgments

I would like to start by a huge thank you to the organisation that agreed for my research to be conducted as well as the participants. Without them this research project would not have been possible.

I would like to eternally thank my family: my mother Resham, my father Ekam, brother Mandip and sister Randeep for all their support and guidance in my achievements to date, but more so this course that I undertook knowing how demanding it would be. In hope that one day this would be a great achievement in making them all proud! I would like to acknowledge a special thank you to my sister, in listening to my daily difficulties as well as successes in completing this research project.

I would also like to thank my head of service Dr Dominic Crowley for allowing me to do this course alongside working in the service. Also a huge and warm thank you to both my manager Dr Shradha Lakhani and clinical supervisor Dr Heidi Napier in all their support in my journey, professionally as well as personally. Their source of support has been invaluable and has definitely been appreciated throughout the course.

A big thank you to Mandeep Kaur, who I had initially met on the course and since then has become a very good friend. I thank her for all her support in this on-going journey, which I am sure, will continue in a different light!

I would like to express gratitude and utmost appreciation for the support and guidance received professionally as well as personally from all my university tutors, especially my research supervisors Dr Wendy Weremiuk, Dr Lee Hubbert-Williams (who then sadly left the course part way through my research) and Dr Robin

Gutteridge (who then joined my on-going research journey). I have enjoyed working on this research with both supervisors. With Wendy's extensive knowledge and expertise in this research area and Robin's qualitative methodological research expertise, I was grateful for such a research team! I would also like to acknowledge a big thank you to all the course tutors and the team at Wolverhampton University, in supporting my cohort in all their successes.

Preface

This research idea was of interest to me partly due to the sessional work I used to do within a weight management programme. Where I worked within a CBT framework and implemented interventions to support obese people in making lifestyle changes. My work focused on their emotions and the impact this can have on their over-eating. Whilst working in this area and with the course of time, I became very interested in exploring what overweight and obese people felt had contributed to their health difficulties and the size they had become. How they felt weight management programmes have helped them as well as the professionals supporting them on this journey. Ideas looking at peoples external environment (i.e. their lifestyle, demands placed upon them and the support they were offered professionally as well personally) as well as internally (i.e. their mood, personal perceptions of their life, expectations and beliefs) all started to feel like a topical piece of research emerging. Combining professional and patients views in weight management services adds not only to the uniqueness of this study but also to the richness of the findings collated.

My interest in this area also came from my personal experiences of always having struggled with weight. The difficulties I had faced and experienced by being overweight. I had made lifestyle changes over the course of the years but maintaining them had not always been easy. The more reading I undertook in this area, I found although there was ample literature on obesity and weight management programmes, there was definitely room for further research in numerous areas. One identifiable gap was the focus of my research, the experiences of both patients accessing weight loss services and professionals working in these areas. For one of the modules in my first year on this course, I reviewed literature looking at the role of

psychology within weight management services, which helped support the idea of my research even more. Personally, generating research in an area where a gap had been identified in the literature, along with it being an area of interest and passion became significant ingredients in the development of becoming a scientist practitioner. It definitely led me to understand that this is an area I would want to be involved in as part of my on-going working career as well as potentially conducting post-graduate research.

Contents

Chapter 1-Literature Review

This review will highlight and argue the importance of counselling and psychological support within weight management programmes. This is an important area for consideration as literature highlights the positive effects when psychology has been incorporated into such programmes. However, despite National Institute of Clinical Excellence (NICE) guidelines, acknowledging psychology, it falls short of recognising this support as a core aspect of treatment. All of the following databases were searched from 1990 to present day: PsychINFO, Web of Science, CINAHL, PubMed and Psychology and Behavioural Sciences Collection, using search terms relating to obesity (obesity, overweight), interventions (weight management programmes, weight prevention programmes, and bariatric surgery) and psychological support (counselling, psychology, and emotional support). These databases had been chosen due to the relevant articles found as a result of the search terms utilised. It was deemed that 1990 was sufficient enough date to search from due to the high number of articles obtained as a result of these search terms.

Inclusion criteria included: defining obesity; prevalence of obesity; NICE clinical guidelines as well as other relevant policy guidelines; studies that reported on examining the role of psychology in weight management services; treatments for obesity (both psychological and non-psychological) and their effectiveness; stigma; qualitative and or quantitative methods; searches wider than counselling psychology were utilised in this review, for example, nursing and education were also included.

Greenhalgh (1997) highlights five essential questions to assessing the methodological quality of published papers. These questions included: whether the

study was original; whom the study was about; whether the design of the study was sensible; was systematic bias avoided or minimised; and was the study large enough and continued for long enough to make the results more credible. These questions had definitely assisted in making sure good quality literature had been reviewed in the current study.

Further to this Morse, Barrett, Mayan, Olson and Spiers (2002), discussed validity and reliability in research are better achieved when the researcher rigorously follows a number of verification strategies. Lincoln and Guba (1985); Graneheim and Lundman (2004), discussed trustworthiness can be divided into *credibility*, which reflects the positivist concept of internal validity; *dependability* which relates more to reliability; *transferability* which is a form of eternal validity; and *confirmability* which is mainly about its presentation. These factors have been considered when reviewing the literature. However, Sandelowski (1993) regarded reliability / dependability as a threat to validity / credibility and questioned many of the usual qualitative reliability tests.

Overall, Rolfe (2006) argued that there is not a consistent agreement on an universal criteria for judging quality in qualitative research. The search for a generic framework for assessing the quality of qualitative research should be abandoned in favour of individual judgements of individual studies. A recommendation that came from Koch and Harrington (1998) was that all research reports both qualitative and quantitative need to be read in conjunction with a reflexive research diary to properly assess the quality, as well as published research papers should include a diary. This is reflective of the current study.

Due to the breadth and extensive literature available within this area, as well as the constraints of the word limit there were important topics within obesity that were consciously overlooked, for example, physical health and co-morbidities.

1.1. What is Obesity?

The World Health Organisation (WHO, 2015) stated that, 'overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. The WHO (2015) stated that Body Mass Index (BMI) is a person's weight in kilograms divided by the square of his height in meters (kg/m2). The WHO definition is: BMI greater than or equal to 25 kg/m^2 is overweight and a BMI greater than or equal to 30 kg/m^2 is 'obesity' (fact sheet No 311).

NICE clinical guideline 189 (2014), advised that BMI should be used as a practical estimate of adiposity in adults. But to interpret BMI with caution because it is not a direct measure of adiposity (2006, amended 2014). Further to this it also stated to consider using waist circumference, in addition to BMI, for those with a BMI less than 35kg/m2 (2006, amended 2014). For men, waist circumference of less than 94cm was low, 94-102cm was high and more than 102cm was very high (NICE clinical guideline 189, 2014). For women, waist circumference of less than 80cm was low, 80-88cm was high and more than 88cm was very high (NICE clinical guideline 189, 2014).

The World Health Organisation (2006) indicated the classifications for overweight and obese (see table 1).

Classification	**Body Mass Index (BMI) (kg/m2)**	**Risk of co-morbidities**
Underweight	<18.5	Low (but increased mortality and morbidity from other causes)
Normal range	18.5–24.9	Average
Overweight	>25.0	
-Pre-obese	25.0-29.9	Increased
Obese	>30.0	
-Class 1	30.0–34.9	Moderate
-Class 2	35.0–39.9	Severe
-Class 3	>40.0	Very Severe

Table 1.1 [Weight classification table] Cut offs may not be appropriate for >65 year olds.

The Foresight report (2007), discussed that causes of obesity are complex and multifaceted. These included: human biology the homeostatic biological system that struggles to maintain energy balance to keep the body at a constant weight; growth and early life development-adiposity rebound is a 'critical period' for children and the impact on their BMI later in life; lifestyle-dietary and physical activity; psychological factors, i.e. peoples beliefs and attitudes; economic-affordability and ease of accessibility and social drivers-the obesogenic environment (Eggar and Swinburn, 2002) all contributed to determining obesity.

1.2. Prevalence of Obesity

WHO (2015), stated worldwide obesity has more than doubled since 1980. In 2014, more than 1.9 billion adults, 18 years and older, were overweight. Of these over 600 million were obese. There were 39% of adults aged 18 years and over who were overweight in 2014, and 13% were obese. Most of the worlds' population live in countries where overweight and obesity kills more people than underweight. They also stated that 42 million children under the age of five were overweight or obese in 2013. But more importantly, the report highlights that obesity is preventable (fact sheet No 311). They estimated that overweight and obesity are the fifth leading cause of death globally and this disease represents a critical health challenge. This necessitated action to be taken from all professionals, including psychology as well as individuals who are struggling with their weight. Further to this in section 1.5.5. (Cost) UK statistics have been discussed and the costs incurred.

1.3. NICE guidance and recommendations

For an overview of the best practice in terms of the interventions for obesity, NICE provides evidence-based guidance for the interventions that should be delivered by weight management services. NICE (2006), looked at strategies for 'obese' (classifying three grades according to the BMI range) and 'overweight' people, including the need for counselling and psychological sessions within this population.

NICE public health guidance 53 (2014) provided recommendations on the provision of effective multi-component lifestyle weight management services for adults (aged

18 and over) who are overweight and obese, for commissioners, health professionals and providers of lifestyle weight management programmes. Primarily, the guidance recommended that lifestyle weight management programmes are multi-component: monitor dietary intake; physical activity levels; and behaviour change alongside being developed by a multi-disciplinary team.

This included input from a registered dietician, registered practitioner psychologist and a qualified physical activity instructor. These recommendations also included guidance on ensuring services causing no harm, involving awareness of the stigma that adults who are overweight or obese may feel or experience and ensuring the tone and content of all communications are respectful and non-judgemental. Thereby, reflecting a good relationship between a healthcare practitioner and their client is important. Although these guidelines recommend behaviour change and input from a registered psychologist they do not explicitly state the psychologists' role in promoting behaviour change. Arguably, it could be interpreted that behaviour change could be promoted by other health professionals too, for example, a nurse or dietician.

NICE clinical guideline 189 (2014), stated 'to include the following strategies in behavioural interventions for adults, as appropriate: self-monitoring of behaviour and progress; stimulus control; goal setting; slowing rate of eating; ensuring social support; problem solving; assertiveness; cognitive restructuring (modifying thoughts); reinforcement of changes; relapse prevention; and strategies for dealing with weight regain' (p20). These strategies are not directly labelled as psychological and

emotional support. Although some of these strategies could be used in a practical way, the majority of these strategies are well placed to be safely explored and attempted in psychotherapeutic sessions. For example, Molinari, Baruffi, Croci, Marchi and Petroni, (2005).These guidelines reflected that psychological interventions are clearly emerging and being recognised clinically for obese patients. But within the guideline, there is an identifiable gap in stating the explicit role of a psychologist in delivering such services.

NICE public health guidance 6 (2007), discussed that there is a lot of psychological literature that provides a number of general models of health behaviour and behaviour change, but concludes that:

> ‘However, it was found that the research literature evaluating the relevance and use of these models is inconsistent. For example, it includes multiple adaptations of particular models, poor study designs and studies that fail to take account of all the confounding factors. Having considered some of the more commonly used models of health behaviour, the Professional Development Group (PDG) concluded that the evidence did not support any particular model (although some have more evidence of effectiveness than others). For this reason, the PDG believes that training should focus on generic competencies and skills, rather than on specific models.
>
> These include the ability to: critically evaluate the evidence for different approaches to behaviour change design valid and reliable interventions and programmes that takes account of the social, environmental and economic context of behaviours. Identify and use clear and appropriate outcome

> measures to assess changes in behaviour employing a range of behaviour change methods and approaches, according to the best available evidence regularly review the allocation of resources to interventions and programmes in light of current evidence' (p9).

These guidelines were published eight years ago, and although NICE have been updating certain guidelines, there does not seem to be anything more recent that specifically focuses on psychotherapeutic interventions within obesity. The clarity of a psychologists' role is not stated, and this deficit raised the importance of the present study, which explored the place of psychology in weight management services.

1.4. Application of Guidelines

The previous section addressed some of the significant clinical guidelines with respect to obesity and it will now be discussed how these guidelines have been exercised in practice or where limitations may exist.

Cade and Connell (1991) conducted a study assessing GPs knowledge, attitudes and practice of managing obesity and weight problems in the UK. GPs had suggested that interventions are most efficient when delivered in facilitated groups, yet only 17% of doctors actually used group counselling sessions. Only 3% of doctors recommended behavioural therapy. This study illustrated some of the treatments and approaches used by GPs when counselling overweight or obese patients. When counselling this group, GPs identified a lack of professional

satisfaction, which resulted in recommendations for GPs to be taught explicitly about psychological approaches in weight loss.

NICE public health guidance 6 (2007), discussed how the PDG was influenced by a number of different theories, concepts and accounts of behaviour associated with obesity. These included: resilience; coping; self-efficacy; planned behaviour; structure and agency; 'habitus' and social capital. (Ajzen 1991, 2001; Antonovsky 1985, 1987; Bandura 1997; Bourdieu 1977, 1986; Conner and Sparks 2005; Giddens 1979, 1982, 1984; Lazarus 1976, 1985; Lazarus and Folkman 1984; Morgan and Swann 2004; Putnam 2000). This indicated that NICE had acknowledged the psychological aspects of an individuals' well-being and the areas that could be supported. However, it is not made clear as to who these professionals would be and how they would best support overweight and obese people using these strategies. This highlighted the need for clarity on professional roles in providing psychological support as well as the role of psychology in treating obesity, thereby adding weight and value to the current study.

Barr, Yarker, Levy-Milne and Chapman (2004), surveyed 514 Canadian dieticians to investigate their role in the management of obesity and the types of approaches used by those who regularly provide counselling to overweight and obese people. Participants reported that they could benefit from additional education on motivation and behavioural modification counselling approaches. A captivating finding indicated that the focus on obesity counselling was on building self-esteem and self-acceptance of individuals' current weight rather than weight reduction. This is somewhat controversial as one might imagine that weight loss is the goal, and that

their self-esteem is unlikely to improve if some weight loss is not achieved. This raises the question of whether acceptance of weight would mean people would be less motivated to lose weight.

Together these studies highlighted the role of psychological variables in the process of weight management, which suggested that psychology, and more explicitly counselling psychology could play a central role in the treatment of obesity. The present study expanded on these findings by exploring the role of psychology within weight management services. The role may be around raising awareness as to what an individuals' satisfactory weight is as opposed to what the guidelines may suggest. If the weight they want to maintain is likely to make them happier, they may be more successful in maintaining this weight, conversely, a goal that is unrealistic and unobtainable is more likely to have a negative impact upon an individuals' mood.

1.5. Treatment

Interventions for weight management have conventionally been nutritional or behavioural (Curioni and Lourenco, 2005), which aligns with the NICE guidelines. Within the NHS, treatment for Obesity is managed within four tiers; which deal with increasingly severe cases of Obesity incrementally (table 1.2).

1.5.1. Bariatric Surgery

Table 1.2 below has been adapted to include the relevant information required for this review from the Joined up Clinical Pathways for Obesity: Report of the Working

Group (2014), which used this table as a reference to illustrate the different types of interventions required at the different tier levels.

Tier	Description of the Service	Patient Journey – what are the characteristics of the service users?
1.Behavioural	Universal interventions-lifestyle weight management services (prevention and reinforcement of healthy eating and physical activity messages). Includes public health and national campaigns. Brief advice. Normally time limited.	Overweight
2.Weight management services	Lifestyle weight management services. Normally time limited.	Individual defined as overweight and needs personal directed interventions in the community. Entry either self-referred or referred, possibly from tier 1. Outcomes include exit programme, continuation with tier 2 services, exit to tier 3.
3. Clinician led multidisciplinary team (MDT).	A MDT clinically led team approach, potentially including physician (including consultant or GP with a special interest), specialist nurse, specialist dietitian, psychologist, psychiatrist, and physiotherapist.	An obese individual with complex needs who has not responded to previous tier interventions. Engagement in tier 3 does not automatically lead to surgery. Entry from either tier 2 or tier 4 or direct entry. Exit to either tier 2 or tier 4 or exit from pathway.
4.Surgical and non-surgical	Bariatric Surgery, supported by MDT pre and post op.	Entry-must have engaged with tier 3. Exit to tier 3 (post op support).

Table 1.2 [Four Tiers of Obesity]

This table reflects Bariatric Surgery being in tier four, where most other options regarding weight loss have been exhausted. The tiered programme also guided which services are offered within them, for example, a psychologists' services are more likely to be offered in tiers three and four. This is reflective of the service in which the current study was conducted.

Commissioning approaches to Weight Management Services vary widely. The NHS and Social Care Act 2012 (DOH 2012) saw Public Health preventative and lifestyle services relocated in Local Authorities, while illness management services became the responsibility of new Clinical Commissioning Groups. Prior to the 2012 systemic re-organisation, prevention and management had both been the role of the Primary Care Trusts, so the transition elicited concerns about potential fragmentation. In the health economy where the research was undertaken, the CCG had commissioned an integrated model of weight management and lifestyle preventative education and support. This provided an opportunity to explore how the role of a counselling psychologist was being utilised within an integrated service.

Lindekilde, Gladstone, Lubeck, Nielsen, Clausen and Vach et al (2015), reviewed the treatment for individuals with severe obesity, including pharmacology, behaviour-based interventions and surgery. Bariatric surgery is usually considered when all other treatments have failed and has been suggested to be one of the most effective treatment options within weight management (Maggard, Shugarman, Stuttorp, Maglione, Sugerman and Livingstone et al 2005; Mamplekou, Komesidou, Bissias, Papakonstantinou and Melissa's, 2005). Lindekilde et al (2015) viewed bariatric surgery as a forced behavioural intervention whereby the individuals' consumption is restricted, even though the presence of food cravings and unhealthy eating habits are still very prominent. They hold that the success of bariatric surgery is not purely about how much weight the patient loses but also on improvements in quality of life.

According to Ballantyne (2003), quality of life is multi-faceted including: physical well-being; mental well-being; and social and or functional being. It is questionable as to the relative importance given to physical weight loss, evident by the scales, versus all other factors contributing to an individuals' well-being, which consequently can lead to weight loss. This had a huge importance for the present study as it looked at the importance of psychology within weight management services, which contributed positively to the emotional well-being of an individual who is attempting and trying to maintain weight loss.

1.5.2. The role of psychological support within weight management

This section reviews literature that looks at the importance and value of counselling and psychology for overweight and obese people in weight management services.

There is a consistent association between obesity and depression, low self-esteem, and poorer quality of life, especially where the person is seeking help (Jones, Grilo, Masheb and White, 2010). It is therefore important to understand the personal processes and experiences of an individual with obesity, with a view to explaining how these associations impact on their lives, and their eating behaviour. Counselling psychology provides a good framework for gaining this understanding.

The British Association for Counselling and Psychotherapy (2012) (BACP) stated 'that counselling and psychotherapy, are umbrella terms that covers a range of talking therapies, where trained practitioners work with people over short or long

term to help bring effective change or enhance their well-being'. This is effective with open communication. Communication is two ways: sending and receiving of verbal and non-verbal information. Scott, Cohen, DiCicco-Bloom, Orzamo, Gregory and Flocke et al (2004), stated weight loss counselling involves: the patient's readiness and willingness to change; seeking their permission to discuss the issue of overweight and obesity; and supporting the patient to set their agenda and goals.

Kushner and Pendarvis (1999) found counselling was valuable for a person to understand their weight difficulties. They stated counselling begins with effective listening (an active process requiring paraphrasing, clarifying and giving feedback), and as the counselling process develops the patient is engaged in further dialogue. The patient's previous successes in weight loss are highlighted to strengthen existing motivation. An action plan is created as a result of what the patient views as achievable and realistic goals. The sub goals are extended to using: tools; techniques; and educational information with a follow up appointment negotiated for reinforcement. An important theme identified is the recognition that obesity is a chronic disease and that lifestyle changes must be acceptable to the patient. One of the possible goals to empower a patient to manage their weight difficulties is to make healthier life choices.

Bidgood and Buckroyd (2005) conducted an exploratory study that examined obese adults' perspectives of their attempts to lose and then to maintain a reduced weight. There were eight participants who were interviewed one to one and the remaining ten formed two focus groups. General psychological themes identified for weight re-gainers were responding to life events by: comfort eating; self-evaluation based on

their appearance; lack of physical activity; and a low degree of attention given for weight control. This study indicated that these obese people wanted to lose weight, hence accept lifestyle changes but also required on-going support to maintain their weight loss. The on-going support was identified as help with diet, exercise and social support. This study also suggested that counselling could have a greater role in the treatment of obesity. This once again highlights the importance of the current study in exploring and potentially establishing the importance and or role of psychology within such services.

Wier, Ariens, Dekkers, Hendriksen, Smid and Mechelen (2009) conducted a study in an overweight working population to investigate the effectiveness of lifestyle counselling in changing body weight. They conducted a randomised control trial with three treatment conditions: intervention materials with phone counselling every two weeks (N=462); a web based intervention with email counselling (N=464); and usual care with lifestyle brochures with no counselling involved (control group) (N=460). For the online group, the counsellor would check the homework via email when the participant had completed a module. The phone group had larger positive changes than the internet group, but overall comparisons revealed no significant differences.

Wier et al (2009) concluded that lifestyle counselling by phone and email is effective for weight management in overweight employees and shows potential for use in the workplace. This study also highlighted phone counselling to be effective for reducing unhealthy eating and increasing physical activity. A limitation of this study is that it is based on self-reporting. The strength of this study is that it included: objective

measurement of body weight; size of the group studied; and recruitment of individuals who had not previously attended a weight loss programme.

Wadden, Berkowitz, Womble, Sarwer, Phelan, Cato et al (2011), were involved in a trial based at University of Pennsylvania (Power up). In the Power trial two behavioural weight loss interventions were compared with a control group of self-directed weight loss. One intervention provided distant support (i.e. telephone, email and internet); the other gave both personal support during individual and group sessions and distant support of behavioural counselling. Results found weight loss was significantly greater in the supported groups compared with self-directed control, but did not differ between the two interventions. It was conclusive that the most-effective weight loss programmes involved high levels of counselling and patient support. They reported that further studies need to look into researching cost effective methods of weight loss counselling. This supported the importance of psychological support within weight management services.

Apovian, Garvey and Ryan (2015) found comprehensive lifestyle management is the core intervention for the treatment of adult obesity. When it is utilised efficiently it can lead to long-term, clinically meaningful weight loss in a representative number of individuals, in weight loss of 5%-10%, being given as a recommended goal and has been known to provide significant health benefits. Comprehensive lifestyle management includes three components: reduced calorie intake; increased physical activity; and behavioural intervention. Behavioural intervention is an essential aspect within promoting weight loss as it provides patients with strategies, for example, modifying cues that lead to unwanted behaviours and self-monitoring, that promote

treatment adherence and achievement of dietary and physical activity goals (Wadden, Butryn, Byrne, 2004). The American Medical Association (2015) emphasised that a comprehensive lifestyle management is the cornerstone of obesity treatment.

Apovian et al (2015) suggested points of further discussion and or research to include: clinicians using a varied range of interventions to support patients in weight loss and provide on-going and adaptable treatment to support the successful achievement of long-term weight and health goals. Overall this study highlighted the importance of counselling and psychotherapy in weight management programmes. Some limitations to this approach included why it may not have been applied universally and if it is as efficient as stated then surely all obesity problems would be solved. There may be costs incurred to be considered with conducting RCTs as well as the expense in terms of the range of practitioners required.

Overall, the literature is in support of there being a role for counselling and psychology within weight management services. What remains unclear is to what extent are they to be involved, as well as what their role would include. The present exploratory study highlighted some clarity to this ambiguity.

1.5.3. Effective psychological therapeutic interventions

Further to understanding the role of counselling and psychology within such services, this review looked at discussing which, if any, specific therapeutic interventions maybe utilised in supporting individuals with obesity. The role of psychology is two-fold: one to support other existing interventions (for example,

bariatric, adherence to exercise and diet, client-patient relations) and two as a specific psychological intervention. Upon reviewing available evidence of effectiveness of interventions for weight management, evidence relating to psychological interventions was limited (NICE, 2007). However, a number of concepts were taken from the psychological literature that appeared helpful when looking to work on behaviour change with individuals. These included: personal relevance (emphasising the personal salience of health behaviours); positive attitude (promoting positive feelings towards the outcomes of behaviour change); self-efficacy (enhancing peoples belief in their ability to change); and relapse prevention (helping people develop skills to cope with difficult situations and conflicting goals).

Safron, Cislak, Gaspar and Luszczynska (2011), reviewed school based interventions targeting obesity-related behaviours. They found that psychological theories and cognitive mediators had a minimal role, in that the most achievable was psychological techniques of behaviour change moderating the effectiveness of interventions. They suggested that future systematic reviews need to focus on the underlying psychological principles applied. Implementation of a psychological theory of behaviour change may help to further explain why some school based obesity treatment programs are more effective than others.

Further to this there are various psychological interventions that have been utilised in managing weight related difficulties. Some of these included: CBT-E; Mindfulness based interventions; and Ecological Momentary Interventions (EMI). CBT-E is formerly known as enhanced cognitive therapy. It refers to a trans-diagnostic psychological treatment for eating disorders as a highly individualised treatment.

This was developed by Professor Fairburn as a treatment initially for bulimia nervosa and has been subject to numerous clinical trials. Fairburn, Cooper and Shafran (2003) modified the treatment in the early 2000s to make it suitable for all forms of eating disorders. Fairburn, Cooper, Doll, O'Connor, Bohn, Hawker et al, (2009) and Fairburn, Cooper, Doll, Palmer and Dalle Grave (2013), stated that CBT-E has shown to be suitable for all types of eating disorders encountered by adults, which is not true of any other treatment. Poulsen, Lunn, Daniel, Folke, Mathiesen, and Katznelson et al (2014), found CBT-E to be more effective than 100 sessions of psychoanalytic psychotherapy delivered over the course of two years.

O'Reilly, Cook, Spruijt-Metz and Black (2014) conducted a literature review looking at the effectiveness of Mindful Based Interventions (MBI) for treating obesity related eating behaviours such as: binge eating; emotional eating; and external eating. They reviewed 21 English peer reviewed journals and found 86% of the reviewed studies reported improvements in the targeted behaviours. They found mindfulness training can be tailored to the specific needs of obese individuals. Providing them with skills to change their eating behaviours and potentially alter their relationship with food. Overall, they found that outcomes from reviewed studies provided evidence to support the use of MBIs with binge, emotional, and external eating. They concluded that the review had growing empirical evidence for psycho-educational and behaviour based treatment for obesity related eating behaviours.

Heron and Smyth (2010) reviewed 27 interventions using mobile technology to deliver psychological interventions to individuals as they manage their daily lives, as an extension to traditional research and clinical settings. EMI are treatments that are

provided to people during their everyday lives, for example, in real time and in natural settings. They reviewed these interventions to deliver ambulatory treatment for health behaviours, including weight loss. Empirical evidence suggests EMI can produce similar weight loss in overweight women to an established CBT intervention and adding EMI to CBT or Psychoeducation can enhance treatment efficacy. All these studies conducted were with samples of 80-100% women, this limits findings for the efficacy of EMI for weight loss in men. They concluded mobile technology based EMI can be effectively used in interventions for a variety of health behaviours, psychological and physical symptoms. A suggestion for future research was to investigate factors that influence a clinicians' willingness to include technology based interventions, for example, cost and time investment, role adjustment and scepticism of the value of technology, as well the lack of technical knowledge present.

However, Le Grange, Gorin, Dymek and Stone (2002) stated that EMI did not significantly enhance standard CBT, which contradicts Heron and Smyth (2010) findings discussed earlier and demonstrated a need for further research.

Minniti, Bissoli, Francesco, Fantin, Mandragona and Oliveri (2007), compared outcome and dropout rates of individual nutritional counselling (IT) and a cognitive behavioural group (CBT) after 6 months of treatment. There were 72 participants in IT and 57 in the CBT group. IT consisted of fortnightly individual meetings with a dietician of 20 minutes, and one medical visit with a physician every third month, for a total of 12 meetings during the first six months of therapy. CBT consisted of ten weekly group meetings, one medical visit with a physician every third month and two booster sessions (on the fourth and sixth month), for a total of 12 meetings during

the first six months of therapy. Each meeting lasted 90 minutes and was conducted by a psychologist and a dietician. IT was found to have a higher drop-out rate than CBT. There were numerous outcomes used to evaluate the psychometric variables.

It was concluded that outcomes of IT and GT were comparable, although the dropout rate of IT was higher than that of CBT, suggesting some characteristics of IT can contribute to attrition. Younger age and better body image was associated with drop-out rates. Due to a short-term lower drop-out rate and the lower cost of CBT when compared to IT, this study argued for a wider use of cognitive behavioural group therapy in obesity services. One of the limitations to this study was its generalisability across the obese population, as all participants were females seeking treatment, which may have influenced motivation. In comparison, often patients on NHS treatment packages may not opt for psychological services, which may in turn influence their motivation. One suggestion for future research would be to evaluate this study over a longer term to observe differences between different treatments.

Another study conducted by Molinari, Baruffi, Croci, Marchi and Petroni (2005) compared different integrated therapeutic approaches for the therapy of Binge Eating Disorder (BED). There was a sample of 65 females who were severely obese, they were randomly assigned one of the three groups: CBT alone; treated with SSRI anti-depressant (fluoxetine) therapy alone; and the third group was a combination of CBT and the SSRI drug. The study was conducted over a period of 12 months. They found that the two groups where CBT had been used resulted in better outcomes than where solely pharmacology was utilised. There was seen to be an improvement in the number of binge eating episodes, maintenance of weight loss reduction from

baseline and psychological well-being. This study highlighted the importance of a MDT approach to treating BED. Once again, the generalisability of this study is under question, as it only consisted of females participating. Further research could consider including participants from both genders.

Conversely, Cooper, Doll, Hawker, Byrne, Bonner, Eeley et al (2010), conducted a study examining immediate and long term effects of a new cognitive behavioural treatment that was specifically designed to minimise post treatment weight regain. A subsidiary aim of the study was to explore the relationship between binge eating, weight loss and weight regain. There were 150 female obese participants who were randomly assigned to three groups. These groups included: *CBT* which was designed to address certain psychological processes that had been predicted to support successful weight maintenance (Cooper and Fairburn, 2001, 2002); *Behaviour therapy* based on the Pittsburgh Behavioural Weight Control Manual (Wing, 1995); and the Weight Maintenance Guide of Wadden and colleagues (Wadden and Foster, 1989). Well established behavioural methods were utilised to support patients in changing their eating habits and activity levels; *Guided Self Help* was based on the LEARN programme designed to produce change in; lifestyle, exercise, attitudes, relationships and nutrition. Participants in this group followed the LEARN programme with minimal guidance and support from a therapist.

Cooper et al's (2010) findings revealed that majority of the participants regained almost all their weight lost within their treatment groups. Despite all treatment completion rates and level of compliance being high, even up to three years post treatment. There were a very small proportion of participants who were able to

maintain either a 5% or 10% weight loss throughout follow up. However, CBT was successful in achieving change in participant's acceptance of shape, even though it did not result in improved weight maintenance.

There were numerous strengths to Cooper et al's study, one of which was that the therapists were well trained and closely supervised. However, one of the conclusions they drew was that it is possible that the processes specified by CBT theory operate well and that their treatment was not sufficiently effective at changing the participants. They acknowledged that it was difficult to ascertain from this study whether the theory was incorrect or whether CBT was not sufficiently potent. They are aware that other processes maybe largely responsible for weight regain. The other conclusive point stated that they had sufficient robust findings to make it ethically questionable as to whether psychological treatments for obesity 'work' in the absence of data on their longer-term outcome. Further to this Cooper et al, also stated that psychosocial research on obesity should perhaps move away from work on treatment and focus on prevention.

Brownell (2010) comments on Cooper's ethical question and claims that is it is a provocative question about declaring victory. She goes onto state that until some long term risk benefit can be proven for people receiving treatment, it is difficult to say that loss and complete regain represents treatment working. From a patient perspective loss and regain can represent failure. Brownell (2010) also comments on how Cooper et al object to the implication that treatments work when they do not, when there is no evidence of significant weight losses being maintained. She finds this to be a valid point and feels obese people are given more hope and initially a lot

of optimism in relation to the actual results achieved. This emphasised the importance of being honest with patients about their odds of achieving a given result. She also stated that this is not to imply that highly effective treatments are not possible in the future but the focus must be on prevention.

The overall literature supports psychological interventions; they are effective within weight loss, which implies the importance of counselling and psychology within such services. This raised support for the present exploratory study to add to existing literature. However, it is evident that there is a lack of coherence in the approaches, and no single unifying theory which underpins or directs them as well as that Cooper et al's (2010) study maybe a result of other factors leading to weight regain as opposed to it solely being a result of the psychological interventions being ineffective.

1.5.4. Long term weight loss and maintenance

In general, a lot of obese people find weight loss a difficult task to achieve, but it seemed that maintaining their weight is viewed as an even more difficult goal (Cullen, 2015). A meta-analysis in the US suggested that weight management strategies remain largely unsuccessful (Anderson, Konz, Frederich, and Wood, 2001), with half (Wadden and Butryn, 2003) to three quarters (Anderson, et al, 2001) of participants usually regaining their lost weight within five years. Furthermore, going on 'a diet' has been associated with disordered eating behaviours, (Polivy and Herman, 1985) long term weight gain, (Mann, Tomiyama, Westling, Lew, Samuels and Chatman 2007) and the negative health consequences of weight cycling (Brownell and Rodin, 1994). It is apparent that the place of psychology is broad and

it applies not only to the delivery of interventions but also to maintenance, adherence and client communications too. This highlighted a huge role for psychological support, not just whilst individuals are losing weight but also continuing into weight maintenance. The present study expanded on these findings to clarifying the importance of the place of psychology in weight management programmes.

It is of note that patients are given a range of instructions and advice to follow, but very few are given appropriate long term guidance and support with how to follow these instructions (Thomas, Hyde, Karunaratne, Kausman and Komesaroff, 2008). This may contribute significantly to the statistics showing that long term maintenance of weight loss is poor. Public health approaches to obesity must engage and consult those currently living with obesity, if service delivery is to be effective and initiate patterns of social change.

Gupta (2014) conducted a literature review ranging from 1991-2014 looking at barriers and facilitators of long term weight loss amongst adults in the UK. He found that in comparison to short term success, there was minimal literature available on factors associated with long term weight loss maintenance. Facilitators included: support from professionals as well as family and friends, and participating in weight loss programmes. Providing a platform to share common interests included discussing potential issues, a psychological boost and self-confidence helped them with maintaining long term weight loss. This clearly indicated the importance of counselling and psychology in supporting individuals to maintain their weight loss and working integratively within the wider systems of families and friends.

Barriers included: lack of willpower; self-sabotage; self-perception of body image; and past stigmatising experiences related to excess body weight (Burdett, 2010; Herriot, Thomas, Hart, Warren and Truby, 2008; Garip and Yardley, 2011). An interesting finding shared was that past stigmatisation emerged as both a facilitator and a barrier to long term weight maintenance. This highlighted the importance of individual differences. Gupta acknowledged that the literature reviewed was small qualitative and quantitative studies, where transferability cannot be claimed, but the same themes were apparent in increasing its validity. He suggested further research to include a randomised control trial establishing causality between long-term weight loss maintenance and its determinants.

In support of Gupta (2014), Elfhag and Rossner (2005) also reviewed literature on weight loss, maintenance, and weight regain. They defined maintenance as intentional weight loss that has been a result of treatment interventions or individual efforts sustained for at least six months. This is the general definition across studies but the specific criteria may differ. For successful weight maintenance, the review highlighted the importance of: initial weight loss; reaching a self-determined goal; having a physically active lifestyle, eating regularly and healthily; having internal motivation to lose weight; access to good social support; improved coping strategies; increased self-efficacy; being autonomous and overall having increased psychological strength and stability. Conversely, they found that factors that pose a risk for weight gain included: a history of weight cycling; binge eating; having more hunger; and eating in response to negative emotions and stress. Once again this highlighted the role of psychological outcomes in weight control, as emotions influenced weight gain through loss of control and binge eating. This reinforced the

importance of the present study looking at such support within weight management programmes.

Elfhag and Rossner (2005), identified initial weight loss as one indicator of success, other studies have examined whether the rate of weight loss influences long term maintenance. For example, Nackers, Ross and Perri (2010), conducted a study examining whether gradual initial weight loss was associated with greater long term weight reduction than rapid initial loss. This included a sample of middle aged obese women (mean BMI of 36.8), who received a six month lifestyle intervention followed by a one year extended café programme. There were three groups: Fast; Moderate; and Slow where participants were assigned to after monitoring one month of their weight loss. The fast and slow groups differed significantly at 18 months.

Nackers, Ross and Perri (2010) concluded that fast weight losers obtained greater weight reduction and long term maintenance and were not more susceptible to weight regain than gradual weight losers. Limitations to this study included the post-hoc separation of groups according to initial rate of weight loss did not account for any underlying physiology or behaviours that may have self-selected participants into each group. They suggested further research into a randomised design to assign participants to these three classified groups to validate their findings regarding initial rate of weight loss. They also suggested within lifestyle weight management programmes that efforts should be focused on promoting large rather than small behavioural changes during the initial weeks of treatment. Here, there was a strong role identified for psychological support in promoting and maintaining such lifestyle

changes, which the present study, expanded on and clarified the value of psychology in such services.

In addition to psychological and surgical interventions, there are other treatments to consider, for example, pharmacology. Although there is no substantive evidence that any drugs lead to long-term weight loss or maintenance (Craighead, Stunkard, and O'Brien, 1981; Reba-Harrelson, Von Holle, Thornton, Klump, Berrettini and Brandt et al, 2008; Ryan, 1996). Ogden and Holloway (2010) found that within six months of taking Orlistat individuals had lost some weight and showed improvements in their diet. Those who lost most weight showed a decrease in beliefs in medical solutions, a decrease in unhealthy eating, an increased belief in treatment control and an increased belief that the unpleasant consequences are both due to their eating behaviour and just part of the drug. They suggested that this may encourage some patients to focus on the behavioural aspects of their weight problem promoting the dietary changes needed for both short and longer term weight loss.

In addition to this, a qualitative study of orlistat users conducted by Ogden and Sidhu (2006), found that by showing patients the fat they consumed, orlistat can shift patients' models of obesity towards a more behavioural perspective, encouraging them to adopt a healthier diet. They argued that orlistat functions by educating patients and creating coherence between behavioural solutions for obesity. However, they are aware this process remains untested in a larger quantitative study. Overall orlistat is currently the most commonly prescribed medication for obesity, there remains much variability in its effectiveness with only a minority of patients showing weight loss. Both these studies highlighted an important role for

psychology in promoting behavioural changes in supporting patients with their weight loss through education and behavioural solutions.

Commercial dieting plans are good for short term weight loss, but have poor long term outcomes (Mann et al 2007). Physical activity programmes can also lack long term evidence (Wing, 1999) and non-dieting holistic approaches, i.e. mindfulness have shown modest weight loss but have improved: self-esteem; self-control; self-efficacy, and more likely to engage in physical activity (Hawley and Lessard, 2008). On a larger scale anti-obesity media campaigns seem to have little effect on behavioural changes (Fishbein, Hall-Jamieson, Zimmer, Von Haeften and Nabi et al, 2002) and increase stigma. On a wider scale government directed public health schemes, for example, food labelling, endorsing physical exercise, menu labelling, regulating junk food marketing does not fully acknowledge the complexity of obesity, and it certainly does not offer robust solutions (Yancey, 2007).

1.5.5. Cost

Butland, Jebb and Kopelman et al, (2007), estimated that the direct NHS costs of treating overweight and obesity, and related morbidity in England have ranged from £479.3 million in 1981 to £4.2 billion in 2007. They also stated that the estimated indirect costs (those costs arising from the impact of obesity on the wider economy such as loss of productivity) from these studies ranged between £2.6 billion and £15.8 billion.

Butland et al, (2007), discussed that modelled projections of the indirect costs could be as much as £27 billion by 2015. WHO (2011) stated that England ranks amongst

the most obese countries in Europe, with an estimated cost of £3.2 billion to the National Health Service NHS (Oyebode and Mindell, 2013; Hojjat, 2015). Research (2008), stated that obesity and related illnesses were estimated to have costs of £148 million in inpatient stays in England. The Scottish Government (2010) identified the total societal cost of obesity and overweight in 2007-08 was estimated to be between £600 million and £1.4 billion, the NHS cost may have contributed as much as £312 million. NICE declared the need to address overweight and obesity as a public health priority in response to such figures recorded.

Whilst these figures suggest an overall increase in the costs of treating overweight and obesity, in the absence of an agreed definition of costs, different studies have defined costs differently. It is therefore difficult to interpret trends and to compare cost estimates between studies. Reports by the National Audit Office (NAO) (2001), the House of Commons Health Committee (HCHC) (2004) and Foresight (Butland et al, 2007) still underpin the majority of publications which have been published about the NHS and wider cost of obesity in the UK. These reports indicated the severity of the problem and more its financial implications on society, thereby necessitating further research to demonstrate a better understanding of obesity and ways of managing it.

The prevalence of obesity is predicted to continue to rise significantly in the near future (Ohsiek and Williams, 2011; Kelly, Yang, Chen, Reynolds and He, 2008). This is reflected in the Statistics on Obesity, Physical Activity and Diet: England (2015), which reported that “there was a marked increase in the proportion of adults that were obese from 13.2 per cent in 1993 to 26.0 per cent in 2013 for men and from

16.4 per cent to 23.8 per cent for women. The proportions that were overweight included, 'obese' increasing from 57.6 per cent to 67.1 per cent in men and from 48.6 per cent to 57.2 per cent in women" (p7). This rise in prevalence has implications for both the cost of treating obesity, and the co-morbidities it presents from the impact that being obese can have on an individuals' physical and emotional well-being.

Obesity is one of the most costly chronic diseases in healthcare concerns (Lehnert, Sonntag, Konnopka, Riedel-Heller and Konig, 2013). It is associated with numerous serious health related consequences including: type 2 diabetes; cardiovascular diseases; neuropathy; and cancer (Mokdad, Marks, Stroup and Gerberding (2004). It can also contribute to psychological disorders, including depression and social stigmatisation (Garvey, Garber, Mechanick, 2014).

Overall, it is apparent that obesity has a negative impact upon the economy. A huge implication is the contribution it makes to the development of a number of diseases including: hypertension; hyperlipidaemia; diabetes mellitus; osteoarthritis; and psychological problems (Karlsson, Sjostrom, Sullivan, 1998; Narbro, 1997). Shaw, O'Rourke, Del Mar and Kenardy (2009) reported that there is also an increase in all-cause mortality in obese people. The relationship between excess mortality and obesity is not straightforward. This highlighted the need to ensure that interventions are effective and within this psychology has an immense role in supporting adherence and acceptance in order to optimise positive effects of treatment.

It is conclusive that there is diverse literature suggesting the various types of treatments and supports offered to individuals trying to lose weight. From guidance offered by NICE to actual weight management programmes conducted nationally as well as internationally (for example, Curioni and Lourenco, 2005; Nackers, Ross and Perri, 2010). There are psychological interventions that focus specifically on eating disorders, especially that of related to Obesity, for example, CBT-E (Fairburn, Cooper and Shafran, 2003); MBIs (O'Reilly, Cook, Sprujit-Metz and Black, 2014); and EMIs (Heron and Smyth, 2010). Showing psychological support to be appropriate and having value in supporting these individuals. Yet it has been highlighted on many occasions where psychology could play a more central role with treating and managing obesity. One important reason for this may be due to the lack of understanding of how psychology can support weight management programmes. In response to this, the present study aimed to elucidate the perceived role of psychology within weight management interventions.

1.6. Improving Service Delivery in Weight Management

1.6.1. Stigma

Frequently, individuals with obesity experience different forms of discrimination, which can have an impact on emotional well-being, and also on their weight. Freidman, Ashmore and Applegate (2008), stated overweight and obese individuals who have been exposed to weight stigma are at greater risk for adverse psychological outcomes including: depression; anxiety; suicidality; negative body image; and reduced self-esteem. In addition to this weight stigma could promote unhealthy behaviours like binge eating, increased calorie consumption and

reluctance to diet (Friedman, Ashmore, and Applegate, 2008; Phul and Latner, 2007; Schvey, Phul and Brownell, 2011), a reduction in physical activity and motivation to exercise (Vartanian and Novak, 2010; Seacat and Mickelson, 2009).

Further to this Schvey, Puhl and Brownell (2014) conducted a study to determine the physiological impact of exposure to weight stigma looking at alterations in salivary cortisol among lean and overweight women. There were 123 lean and overweight women. Participants' salivary cortisol was assessed before and after a weight stigmatisation or a neutral video. Their findings indicated that exposure to stigmatising stimuli was physiologically arousing for all women irrespective of body weight. They concluded that weight stigma may induce physiological stress and contribute to adverse health. Therefore the importance of removing stigmatising content from public health is needed to address obesity. The role of stigma in weight management has also been recognised in NICE public health guidance 53 (2014) the PDG state:

> 'people who are obese may perceive or experience stigma on a daily basis, and that any failure to lose weight (or regaining weight following weight loss) may have a negative psychological effect. Although this should not be a reason to avoid managing weight, it does highlight the importance of adopting a respectful, non-judgemental approach. It also highlights the importance of providing long-term support. The PDG noted that it is vital people are enabled to make informed choices about if, when and how they manage their weight' (p 25-26).

The approach of being respectful and non-judgemental can be utilised by practitioners when working with obese individuals. This would help build trust and a good relationship between staff and service users in hope of producing good weight loss results.

Weight bias has been highlighted as an area of concern (for example, Schwartz, Chambliss, Brownell, Blair and Billington et al, 2003; Foster, Dadden, Makris, Davidson, Sanderson and Allison et al, 2003), especially by professionals supporting patients with weight difficulties. A challenging area identified, is that it requires more work from every professional at every level to address the gaps in providing a more succinct and efficient service. Overall, there is a huge gap in identifying a unified given structure (s) to a weight management programme. This clearly impacts on the type and level of psychological input recognised as well as implemented clinically, as psychological input could be in the form of training professionals in raising awareness and ultimately combating stigma

Ratcliffe and Ellison (2013) stated that the prevalence of weight-related stigma is well established, but there is a lack of information about the interplay between external and internal weight stigma. They aimed to synthesise the ongoing psychological effects of weight stigma into a formulation model that addressed the maintenance of internalised weight stigma. Ratcliffe and Ellison (2013) identified cognitive, behavioural, and attentional processes that maintain psychological conditions where self-evaluation plays a central role and developed a model based on clinical utility.

Ratcliffe and Ellison (2013) highlighted the impact of negative societal and interpersonal experiences of weight stigma on how individuals view themselves as an obese individual. At the core of their model was processing of the self as a stigmatised individual. Maintenance factors for obesity and weight stigma included: negative self-judgements about the meaning of being an obese individual; attentional and mood shifts and avoidance and safety behaviours; as well as eating and weight management behaviours becoming deregulated and maintained by both obesity and stigma.

Ratcliffe and Ellison (2013) provided a framework for formulating as well as intervening with internalised weight stigma, and making therapists aware of the applicability and transferability of strategies that they already use with other presenting problems. This model clearly shows the importance of psychological factors related to stigma and overall weight loss. Hence, reflecting a potentially strong role for psychological support with stigma related issues. They acknowledged that there would be individual differences in the specific maintenance factors and clinicians may need to add idiosyncratic maintenance factors that are not included in the general model.

Ratcliffe and Ellison (2013), suggested further research could include the application of this model and treatment strategies in a group setting, given the success of existing group interventions for internalised mental illness stigma (for example, MacInness and Lewis, 2008).

Whilst stigma from within the community can have a detrimental effect upon an obese person, what is more challenging is the stigma they may perceive from healthcare services. This perception may even prevent or delay help seeking in some patients. Obese individuals can: feel disrespected by providers; perceive that they will not be taken seriously due to their weight; report that their weight is blamed for all of their medical problems; and are hesitant to address their weight concerns with health professionals. This suggested a substandard healthcare experience for obese individuals (Anderson and Wadden, 2004; Brown, Thompson, Tod and Jones, 2006; Amy, Aalborg, Lyons and Keranen, 2006).

Puhl and Heuer (2010), found for women at the highest levels of obesity, 68% reported that they delayed seeking healthcare because of their weight, and 83% reported that their weight was a barrier to getting appropriate health care. With obese individuals being more prevalent to weight related comorbidities, quality of health care is vital. Acknowledging the detrimental effects to weight stigma in health care is important for a better understanding of the impact of weight stigma on engagement with health services.

Davis-Coelho, Waltz and Davis-Coelho (2000), suggest that it is important for clinicians to reflect on their own attitudes and beliefs about obesity, as this has an impact on: the therapeutic relationship; formulation of difficulties, for example, over-emphasising beliefs about responsibility; controllability and motivation; as well as beliefs about prognosis of sub-optimal therapy.

In response to this, Epstein and Ogden (2005) interviewed GPs in the UK about their views of treating obesity. They conducted a qualitative study looking at exploring GPs views about treating patients with obesity. They interviewed 21 GPs and analysed the data using Interpretative Phenomenological Analysis (IPA). GPs primarily believed that obesity was the responsibility of the patient, as opposed to a medical problem. This is interesting, as it has been found that people have more positive beliefs about obese individuals when they believe that their obesity is attributed to a medical condition beyond the individuals' control (Allison, Basile and Yuker 1991; DeJong, 1980). GPs also felt that existing treatment options were ineffective. They concluded that although GPs believe patients want them to take responsibility for their weight problems, it is not within their domain to facilitate this.

Epstein and Ogden (2005) found that GPs reported on occasions that they have offered inappropriate treatments, in order to maintain good doctor-patient relationships. Until more effective treatments are made available GPs are unconvinced that obesity is a problem requiring their clinical expertise and may continue to resist any government pressure to accept obesity as part of their workload. One of the limitations to this study was the extent to which the attitudes held actually influence the care that is provided, as a medical practitioner would be bound by professional ethics. A larger scale quantitative study of GPs beliefs would be more representative of the findings. Epstein and Ogden (2005) reported that their results provided support for existing research indicating that GPs believe obesity is primarily the responsibility of the patient and is in line with studies where GPs think the primary causes of obesity are over eating, which is within the patients control (Ogden, Bandara and Cohen et al, 2001). Further research maybe required to

investigate where these responsibilities lie and what roles need to be managed in providing effective treatments for obese individuals.

Further to this Pollak, Ostbye, Alexander, Gradison, Bastian and Brouwer et al (2007), reviewed weight related topics discussed between physicians and their overweight and obese female patients in the USA. They found 46% reported attempting to lose weight after the physician had provided counselling regarding nutrition, as opposed to 37% who were not counselled. Physicians (although not defined explicitly in the study seemed to have similar roles to that of GPs) are infrequently trained on how to provide weight loss counselling. One of the effective counselling approaches identified was Motivational Interviewing (MI). When physicians were empathic and used techniques such as MI, patients reported changing their lifestyles to try and lose weight. This indicated that potentially physicians can improve on their counselling skills. A limitation to this study was the sample size; therefore a larger sample size may reflect more generalisability. A practice recommendation identified was that a physicians' empathy and collaborative approach can have a positive effect on women's weight loss efforts.

If obesity is to be addressed on a national scale, then front line medical practitioners are important, as they see the largest sector of the population. They have a much further reach than psychologists. This once again highlighted a strong role for psychology in raising awareness and psycho-education on understanding obesity and the impact it can have on an individual. This also supported the idea of conducting the present research to establish the role of psychology within such services.

Pomeranz (2008) discussed how historically governments have failed to respond appropriately to diseases that primarily impacted upon socially undesirable groups. Obesity has been viewed as a personal failing; so it is not addressed 'on par' with non-stigmatised medical conditions (Pomeranz, 2008). Rather than composing a comprehensive plan to address the obesity epidemic, policymakers have mainly focused efforts on education to those struggling with weight issues. Puhl and Heuer (2010), state that weight stigma threatens the psychological and physical health of obese individuals, impacts upon the implementation of effective efforts to prevent obesity and exacerbates disparities. The stigmatisation of obese individuals is linked to social inequalities; obesity is more prevalent amongst poor and minority groups living in disadvantaged areas (Zhang and Wang, 2004) already being subjected to multiple stigma statuses.

It is fair to state that large scale anti-obesity media campaigns have had little effect on behavioural change (Fishbein et al 2002) and increases in stigma. Further to this Puhl, Peterson and Luedicke (2012) findings have important implications for framing messages in public health campaigns to address obesity. They suggest that certain types of messages may lead to increased motivation for behavioural changes amongst the public, but others may be perceived as stigmatising and instill less motivation to improve health.

One potential way to tackle this is by valuing the importance of gaining an understanding from obese individuals' perspectives. There may be occasions where they do not feel heard or are simply required to follow a programme as well as

complete a prescribed battery of questionnaires which can give a limited range of responses. In line with NHS priorities involving patients in research to help shape practice is seen to be very important. For example, a charity called INVOLVE specialises in public participation. They aim to inspire, innovate and embed effective citizen engagement, so that members of the public are able to take and influence the decisions that affect their lives. Involve supports organisations, politicians and public officials to transform the way they engage with citizens. They have found from experience and research that when public participation is achieved well then it can help to: identify solutions to complex problems; improve the efficiency and effectiveness of public spending and services; promote social cohesion and social justice, and overcome conflict; build the confidence and agency of individuals and communities as well as improve well-being and reduce social problems.

One of the suggestions Puhl and Heuer (2010) advocated for improvement of such issues is with more local and national resources being allocated towards obesity prevention, as it is important to ensure that resources are used productively and that weight stigma does not undermine new efforts. They suggested that one of the resources which could support managing weight stigma is psychological input. This once again highlighted the importance of psychology within weight management services. This then followed on to explore improvements with managing obesity.

1.6.2. Developments in managing Obesity

An unpublished review was conducted by the researcher for the present study in 2012, looking at interventions to improve health professionals' management of obesity. It was found that potential barriers to effective obesity included; a lack of access to appropriate support services by health professionals and a lack of motivation within practitioners to work with this group, owing to negative perceptions of overweight and obese people as well as about the efficacy of treatments, for example see Bidgood and Buckroyd, (2005); Barr, Yarker, Levy-Milne and Chapman (2004).

Further to this Brownell (2010) reported that treating obesity is necessary, and that obese individuals' do require support. The idea of developing highly effective treatments does not rule out the potential fact of this occurring at some point in the near future. If the goal is to have fewer people struggling with obesity and to reduce associated costs, then the focus must be on prevention. This is potentially more likely if there is a unified approach taken.

The present review has highlighted the lack of an unified approach within weight management, as mentioned earlier. In contrast, the approach taken towards the management of smoking cessation is closely informed by theoretical work. For example the Trans-theoretical model (TTM) has been frequently applied to this particular health concern (Di Clemente and Prochaska, 1982). This model describes the five stages of change as shown in table 1.3 below:

- Pre-contemplation (has no intention to take action within the next six months),
- Contemplation (intends to take action within the next six months),
- Preparation (intends to take action within the next 30 days and has taken some behavioural steps in this direction),
- Action (has changed overt behaviour for less than six months) and
- Maintenance (has changed overt behaviour for more than six months).

  People may cycle through the stages several times before achieving long-term behaviour change.

Table 1.3 [TTM-Five stages of Change]

Using these five stages, interventions focused on the presenting issues at each, and targeted interventions appropriately for the level the individual is at. TTM also included several different constructs including the pros and cons of changing (decisional balance), confidence and temptation, and the process of change.

Cabezas, Advani, Puente, Rodriguez-Blanco, Martin and the ISTAPS study group (2011), evaluated the effectiveness of a stepped smoking cessation intervention in a primary care service based on the TTM of change. There were 2827 smokers who attended 82 of the primary care centres participated. The intervention group had six months of brief motivational interviews for smokers at the: pre-contemplation – contemplation stage; a brief intervention for smokers in preparation to action who were not looking for help; an intensive intervention with pharmacotherapy for smokers in preparation to action stage who wanted support in reinforcing the intervention in the maintenance stage**.** The control group received usual care**.**

Results indicated that a stepped smoking cessation programme based on the TTM significantly increased smoking abstinence at the two year follow ups amongst these smokers.

This model exemplifies how weight management services could be structured. Some research mentioned in this paper looked at certain aspects of the TTM model used within weight loss programmes, for example, Wier et al (2009) but there did not seem to be any that had tested this model fully within a weight management programme. Therefore, it needs to be tested in a clinical population.

Further to this Bridle, Riemsma, Pattenden, Sowden, Mather and Watt et al (2005), discussed that there are fundamental differences between some health behaviours and addictive behaviours that the model was originally formulated upon. The lack of evidence maybe due to the fact that some behaviours are more suited to stage based interventions. Povey, Conner, Sparks, James, and Shepherd (1999), demonstrated the problematic nature of adopting a stage-based approach to dietary change interventions. In which case it can be anticipated that stage based interventions would be more effective with some target behaviours than others.

Mastellos, Gunn, Felix, Car, Majeed (2014), stated that the trans theoretical stages of change (TTM SOC) model has been considered an useful intervention in lifestyle modification programmes, but its effectiveness in supporting overweight and obese individuals in sustaining weight loss has been found to vary considerably. They conducted a systematic review that assessed the effectiveness of dietary and physical activity interventions based on TTM and SOC to produce one year plus

sustainable weight loss in overweight and obese adults. The evidence to support the use of TTM SOC in weight loss interventions has been inconclusive due to it being limited by risk of bias and imprecision. When combined with diet and or physical activity as well as other interventions, they found very low quality evidence that may lead to better dietary and physical activity habits.

A systematic review by Mastellos, Gunn, Felix, Car, Majeed (2014), highlighted the need for improved RCTs to produce firm conclusions regarding the effect of TTM SOC lifestyle interventions on weight loss. This highlighted an area where a stronger unified approach could develop and provide an improved way of tackling weight loss. Using the TTM approach would require agreement on structures of what would be offered at set stages. Psychological support therefore maybe considered within these stages. But before this is possible it would be important to determine the importance of this in weight management programmes. Hence, the value of the current research conducted. Bridle et al (2005) explored that the lack of evidence with evaluating TTM and health behaviours maybe partly due to poor model specification, and in part the inappropriate way in which interventions have been developed and delivered. They acknowledged that theoretically consistent intervention studies are required to assess the effectiveness of TTM interventions that are explicitly designed to test key theoretical principles of TTM, and to determine conceptual validity of stage based models in general.

The lack of a consistent theoretical framework or single unifying approach, within the literature on weight management, is reflected in the obesity NICE guidelines (2006) too, where there seems to be little underpinning to the psychological approaches that

are recommended. Further amendments of these guidelines, as mentioned earlier, highlighted it to be a developing area with more being added regarding psychological support. But there is no clear structure of how a programme and service could operate. However, this is not unique to the obesity guidance, as it is noted that the NICE guidance (2008) for smoking cessation programmes does not specify a theoretical model to follow either. One large disadvantage of the TTM being used across weight management programmes, would be that it would create an 'one fits all' approach as opposed to having the flexibility to tailor programmes for individual needs which in itself is the bedrock for receiving psychological support.

It is difficult to target one programme fits all, but then it is questionable as to why some obese individuals do much better than others. This is in view of the same services being offered. It would not be unreasonable to identify motivation as a significant factor in how well obese individuals lose weight. For example, Kushner and Pendarvis (1999), stated that motivation is not easy to assess and it proves to be a difficult area to judge. They define motivation to be an internal state, where the patient can express themselves verbally and behaviourally. It is questionable as to how we measure motivation. The measurement of motivation may contribute to developing better research in understanding improved weight loss results and support offered and hence, more effective weight loss programmes.

A lot of the research discussed so far, has been either predominantly based on female samples, or the gender of the participants was not seen to be important to be reported. It is important to note that clarity on gender could help aid further developments in aiming the right interventions for obese individuals. There could be

some psychological approaches and or weight loss interventions that may work better with men than women. For example, physical activity maybe better received by men than women (Serdula, Mokdad, Williamson, Galuska, Mendelein and Heath (1999).

It is also fair to say that lifestyle interventions tailored to promote and encourage Black Minority Ethnic (BME) communities involvement would prove to be beneficial for society, especially when there are statistics to suggest they are more prevalent to obesity as well as co-morbidities (National Obesity Observatory, 2011). For example, Resnick, Valsania, Halter and Lin (1998); Mokdad, Ford, Bowman and Nelson (2000); Davidson (2001); Okosun, Chandra, Boev, Boltri, Choi and Parish et al (2004); Hertz, Unger and Ferrario (2006) and Li, Ford, Lisa, McGuire and Mokdad (2007), stated that the disproportionate impact of diabetes on minorities in the USA is partly due to the higher prevalence of obesity, especially abdominal obesity in minority groups. Many diabetes prevention programmes recognised this relationship and tried to manage this by promoting weight loss among obese populations (Liburd and Vinicor, 2003; Burnet, Elliott, Quinn, Plaut, Schwartz and Chin, 2006). Although focusing on BME is not an aim for the present study, but if any findings are indicative for this population then naturally that can only enhance any recommendations suggested and support the generalisability of the research overall.

1.7. Conclusion

This review positively indicated a role for counselling and psychological support within weight management services. The literature has highlighted that there could

be a lot more involvement from counselling and psychology to manage the success of weight loss. This identified the need for further research into the content of counselling and psychological support and potential aspects and approaches that might promote behaviour changes. There are gaps identified, where NICE guidance could suggest further as to how psychological support could be integrated better into weight management services, and define the role of psychologists in such a programme, for example, their level of influence in the multi-disciplinary teams and or developing and facilitating interventions, i.e. therapeutic group work (Minniti et al, 2007). Group work is another method of cost effective treatment, which means it may reduce waiting time. But naturally, it comes with its limitations, for example, not meeting the needs of these individuals who require individual support at the time. In order for less obese people to struggle and to reduce associated costs prevention must be treated as a priority (Brownell, 2010).

1.8. Aim of this research

This review of literature has highlighted the need to explore both professional and patient perspectives on the importance of psychological support in weight management programmes. The reasoning for combining both professionals and patients views was due to the lack of literature reflecting this, especially when looking at how similar (if at all) both population group ideas were regarding weight management.

1.9 Objectives of this research

The findings of this review have been used to highlight the importance and effectiveness of counselling psychology with obesity related difficulties. It was also used to make suggestions for future service improvements.

- To explore patient experiences of attending a weight management programme.
- To explore professional and patient views on the importance of psychological support within weight management programmes.
- To elicit health practitioners and patients views of the barriers to access and limitations of the current support offered.
- To identify what health practitioners and patients views are regarding the current and potential contribution made by national policy, guidelines and standard clinical practice.

The following chapter introduced and then discussed the methodology utilised in this study.

Chapter 2- Method

2.1. Methodological Approach

A qualitative research approach was adopted for this study as it was accepted that there are a range of ways of making sense of the world and this study was concerned with discovering the meanings seen by those who were being researched as opposed to the researchers (Ezzy, 2002). Although quantitative methods such as randomised controlled trials can be an appropriate means of testing the effect of an intervention, a qualitative exploration of beliefs and understandings is likely to be needed to find out why the results of research are often not implemented in clinical practice (Haines and Jones, 1994).

The significance of exploring psychological support within weight management services initiated from the researcher speaking to some professionals and through those conversations, it became apparent that services such as the one recruited from for the present study, used psychological therapy sessions as optional and ad-hoc, yet literature reported on the importance of psychological contribution being a core part of such services. Therefore this exploratory study was aimed to gain an understanding of both the professionals and participants' experiences of either working in weight management services or having attended the programme for weight related difficulties. All participants were recruited via a NHS weight management programme, after receiving approval from the university ethics committee and NHS research ethics committee for accessing NHS patients. Data was collated using semi structured interviews.

Inductive thematic analysis (TA) was seen to be the most appropriate form of analysis for this research. It was decided to utilise an exploratory qualitative study with the outcome intended to have clinical utility. It is important to be aware of the co-creation of meaning from the accounts of the participants and conceptual explanations that can arise from the data. This arguably adds authenticity to the findings as well as clinical utility.

TA was viewed as an appropriate method of analysis for exploring professional and patient experiences of the importance of psychological support in weight management services. Braun and Clarke (2006) argued that it offers an accessible and theoretically flexible approach to analysing qualitative data. Reicher and Taylor (2005), stated that the theory and method needed to be applied rigorously, 'rigour lies in devising a systematic method whose assumptions are congruent with the way one conceptualises the subject matter' (p549).

The strength of this approach was that through its theoretical freedom, TA ultimately provided a flexible and useful research tool, which can provide a rich and detailed, yet complex account. In this study it would be the detailed accounts of both the professionals and patients perspectives of psychology within weight management programmes. This was also viewed as an appropriate approach in conducting research within counselling psychology as it is in line with qualitative methods utilised within psychological research. Attride-Stirling (2001), stated qualitative psychologists needed to be clear about what they are doing and why, and include how their analysis was conducted in their reports.

Originally, GT was considered a suitable qualitative methodology, as this provided both a methodology and a structured method to guide the field work and analysis to help manage some of the challenges of subjectivity, as well as determining when to stop data collection (Smith, 2003). But due to timescales reflecting the Professional Doctorate schedule and the routes available to recruit and access participants, it was decided that a pure GT study was unfeasible. A limited window of opportunity from the host Trust to access participants meant that participants would need to be involved in rapid succession. This would not allow for the iterative process that is fundamental to GT. Therefore, it was decided to utilise a thematic analysis, within this exploratory qualitative study.

Completing a rigorous and ethical study was important to generate reliable and trustworthy findings (Guba, 1981). The guidance regarding the analytical phase were appealing to an inexperienced researcher because these processes of coding and clustering the data into ever more abstract categories supported a consistent approach to interpreting the data. In turn this yielded robust, auditable categories and themes (Streubert and Carpenter, 2003; Van Manen, 1990; Ricoeur, 1976), adding credibility and trustworthiness to the overall findings of the current study.

Braun and Clarke (2006) stated that there is no specific ideal theoretical framework or method for conducting qualitative research. They suggested that thematic analysis was a method for identifying and analysing patterns in qualitative data. They emphasised the theoretical flexibility of TA and identified it as an analytical method to be incorporated within an overarching methodology.

Braun and Clarke (2006), viewed TA as theoretically flexible due to the search for, and examination of patterning across the data and the way it is offered by the participant. This did not require adherence to any particular theory of language and or communication, or explanatory framework that helped construct meaning for human experiences or practices. Therefore, Braun and Clark suggested that TA can be applied within a range of theoretical frameworks; from essentialist to constructionist.

Braun and Clarke (2006) suggested that thematic analysis can result in a robust explanation that is derived from the data. Inductive TA is a process of coding the data without trying to fit it into a pre-existing coding frame or any researcher preconceptions. This type of TA is data driven. This research also adopted a constructionist perspective, looking at meaning and experiences being socially produced and reproduced rather than within individuals (Burr, 1995). TA conducted within this framework focused on theorising socio-cultural contexts and the structural conditions within which this data sits (Braun and Clarke, 2006). As such, and accepting that TA reflects a robust method of analysis, it was decided as the framework for the present study's data.

Attride-Stirling (2001), stated how insufficient attention is often paid to reporting the process and detail of analysis. For all these reasons, a research design that utilised TA was felt to be an appropriate framework for the current exploratory qualitative study.

In consideration of ethical issues Shenton (2004), discussed that one of the areas questioned by positivists is the trustworthiness of qualitative research, possibly that their concepts of validity and reliability cannot be addressed in the same way as naturalistic work.

The constructs proposed by Lincoln and Guba (1981), stated that trustworthiness of a research study is important in evaluating its worth. Trustworthiness involved establishing: credibility (confidence in the 'truth' of the findings; transferability (showing that the findings have applicability in other contexts); dependability (showing that the findings are consistent and could be repeated); and confirmability (a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest).

Merriam (1998) explored credibility as "how congruent are the findings with reality?" Lincoln and Guba (1985) stated that ensuring credibility is one of the most important factors in establishing trustworthiness. They suggested 14 provisions to researchers to promote their confidence. Some of these will be looked at in detail; the adoption of research methods established well both in qualitative investigation and information science too. The specific procedures used, for example, the line of questioning pursued in the data gathering sessions and methods of data analysis should be derived, where possible from those that have been successfully used in previous similar research. For this research interviews had been used with Thematic Analysis and both this method of data collection and analyses had been used much in qualitative data, for example, Griffiths, Ryan and Foster (2011).

Dependability is in relation to reliability. Positivists (belonging to epistemology which can be associated as a philosophy of knowing, whereas methodology is an approach to knowing) employ techniques to show that if the work were repeated, in the same context, with the same methods and with the same participants, similar results would be obtained.

Shenton (2004) stated to address the dependability issue more directly; the processes within the qualitative study should be reported in detail, enabling a future researcher to repeat the work, in view of not necessarily to gain the same results. Such in-depth coverage allowed the reader to assess the extent to which proper research practices had been followed. This allowed the reader of the research to develop a thorough understanding of the methods of effectiveness, to include describing what was planned and executed, as well as addressing in detail what field of work was conducted and evaluating the effectiveness of the process of the research undertaken. In the present study, there is a considerable level of detail given in regards to the design, type of participants and the procedure carried out as well as the analyses undertaken.

Shenton (2004) discussed that confirmability referred to the steps taken to ensure that the study's findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher. In relation to the current research TA is very much focused around the researchers' interpretation of data, although this does not mean that the data has been distorted but it is open to interpretation by the researcher and her supervisors. One may state that this can impact on the confirmability of this research.

Further to this Pannucci and Wilkins (2010), stated selection bias may occur during identification of the study population. The ideal study population is clearly defined, accessible, reliable, and at increased risk to develop the outcome of interest, which may within itself be perceived as bias towards the findings obtained. They state when a study population is identified, selection bias occurs when the criteria used to recruit and enroll patients into separate study cohorts are inherently different. In this research there maybe a number of factors impacting on the confirmability of this research; including the specific participants chosen (either a professional or patient of a specific weight management service within a NHS trust), and professionals and patients recruited differently.

Whereas, Patton (1990) recognised the difficulty of ensuring real objectivity, as even tests and questionnaires are designed by humans, the intrusion of the researcher biases is inevitable. There may be more room for subjectivity in qualitative inquiry than quantitative, but this also shapes the findings. For example, the present study analysed perceptions of professionals and patients that are very subjective accounts within themselves. But to add to this the researchers presence during interviews conducted, as well as TA creating sub themes and main themes from the researchers' perspective. Miyazaki and Taylor (2008) furthered this by stating that the mere fact of the researcher being present during data collection creates bias within itself.

Beliefs underpinning decisions made and methods adopted should be acknowledged as well as the reasons for favouring one approach when others could have been used explained, as well as the weaknesses and actual techniques used discussed in

the approach. Any preliminary theories that were not borne out of the data should be discussed, which may occur from on-going 'reflective commentary'. There is also the idea of developing a 'data-orientated' approach, showing how the data eventually led to the formation of recommendations was gathered and processed during the course of the study. In view of the present research there is a significant level of detail attempted to cover the areas mentioned under confirmability. For example, earlier in this section the rationale is explained as to why TA was seen to be the most appropriate form of analysis for this research.

2.2. Design

A qualitative approach was taken using one-to-one interviews, and analysis using TA.

2.3. Materials

A voice recorder was used for capturing the interviews and two separate interview schedules were designed and used with professionals (Appendix 2) and patients (Appendix 3). The major themes covered within the interview schedules included are described in the procedure.

2.4. Participants

There were five health professionals interviewed who were working in weight management services in a NHS setting and four patients who had attended this weight management programme; where two had accessed psychological support and two had not. Participant characteristics are described in table 2.1.

2.4.1. Inclusion and Exclusion criteria

1. Staff working in a NHS weight management service. They did not need to have worked there for a set period of time.
2. Obese Patients (BMI 35+) who have attended a NHS weight management programme. They will have been offered psychological support as part of the programme.

In view of maintaining anonymity, any details that would lead to the identification of participants was omitted or changed and Pseudonyms (false names) were chosen for all participants when they are discussed in Chapter 3: Results and Discussion section, as shown in table 2.1 below.

Pseudonym	Professional / Patient	Their role and involvement in weight management services
Dave	Physiologist	Provides physical activity advice and help in the on-site gym.
Kate	Physiologist	Provides nutritional advice on the programmes
Amy	Health Psychologist	Providing psychological support in individual and group sessions.
Diane	Programme Manager	Overseeing the logistics of the programme.
Jim	Medical Consultant	Medical support offered to patients on the programme.
Gill	Patient	Struggles with Chronic Fatigue Syndrome and or ME.
Barbara	Patient	Struggles with Chronic Obstructive Pulmonary Disease.
Ella	Patient	She has had heart attacks and a stroke.
Bob	Patient	He has had a heart attack in the last year and struggles with depression.

Table 2.1 [Participant characteristics.]

2.5. Procedure

Once university and NHS ethical approval was granted, participants were recruited from weight management services in an NHS setting. The researcher contacted the staff through email with an explanation of the study and what was required of them, as well as a copy of the information sheet (Appendix 4) and consent form (Appendix 5). All professionals approached agreed to take part. Once they responded and consented, then a mutually convenient time was agreed for the semi-structured one-to-one interviews for up to an hour to take place at the centre. Bauer and Gaskell (2000) recommended that the interviews should last 45 minutes -1 hour. The semi-

structured interview schedule with professionals looked at their views on: what is working well; how these programmes could be improved; what they feel they needed to do to help support their clients; what patterns they are noticing with patient struggles and reasons behind this; as well as their understanding of the role and importance of counselling and psychotherapy within weight management and supporting sustaining weight loss.

With patients, in accordance with guidance from the British Psychological Society (BPS) ethical guidelines, if the participants consented to proceed through the gatekeeper (one of the staff members in the weight management service), they then provided the patient with an information sheet (Appendix 6) and consent form (Appendix 7). The gatekeeper then shared the participants contact details with the researcher so that a mutually convenient date and time could be arranged to meet with the participants at either the centre or their home to conduct a semi structured interview for up to an hour. The gatekeeper contacted two patients who initially agreed to take part but then decided not to proceed. One felt that he had a number of appointments to attend at the time and was busy, and the other patient did not specify a reason for withdrawing. Patients' interview schedule looked at: gaining an understanding of their views of such services; what they have found helpful and where there is room for improvement; their understanding of psychological support in weight loss as well as maintaining it; and their understanding of the role of a counselling psychologist within such services.

After interviews had been recorded for both professionals and patients, ethical considerations were adhered to. They were debriefed (Appendix 8 and 9) and

emphasis was placed on the importance of maintaining confidentiality, as well as addressing any of their needs, i.e. any feelings of discomfort as a result of being interviewed, by providing them with a number of a relevant professional if required.

2.5.1. Analytical Procedure

The phases of TA outlined by Braun and Clarke (2006) were followed. Patton (1990) discussed the importance of recognising that qualitative analyses are guidelines and not rules. To follow the basic precepts, but apply flexibly to fit the research questions and data. To reinforce that analysis is not a linear process, where one simply moves from one phase to the next but more a *recursive* process, where one moves back and forth as required, throughout the phases. Ely, Vinz, Downing and Anzul (1997), stated that it is a process that develops over time and should not be rushed. Firstly, the data was transcribed verbatim and through this process the researcher became familiar with the data. **Pseudonyms were added at this time, and any identifying details were removed.** The transcripts (Appendix 1) were read and re-read and initial ideas were noted.

Secondly, this led into coding (process of identifying words and phrases) in the data, which led onto creating meaningful groups. Coding was conducted after working through the entire data set making notes and highlighting potential patterns, a list of codes were generated. From the list of codes (see Appendix 11), Braun and Clarke's (2006) third phase of searching for potential themes began, where a thematic map was produced in order to ascertain the main themes. These themes were then refined numerous times to determine a list of the main and sub themes, as well as give consideration for the inter-links between them. For example, the sub-themes

'ideal' and 'actual' were initially named as 'ideally versus realistically'. After refining this subtheme it was renamed 'desired versus actual'.

This led onto the fifth phase of defining and naming themes, with further refining and discussions with the supervisory team it was finally decided to separate this one sub-theme into two and rename them as 'ideal' and 'actual', and this was better placed under the main theme of Quality of Life. This was reflecting ideally how quality of life *could be* versus *actually* how it may be (please see Appendix A, for a detailed account of the process and steps taken to form the sub and main themes and diagrams reflecting this). Finally, the sixth phase of writing it up with contextualising the theme into existing literature will be discussed accordingly in Chapters 3 and 4.

Tension was a pivotal theme to this study's findings. This was a result of both professionals and patients experiencing this on many levels, including health difficulties to organisational criteria to adhere to. Tension was apparent within the other four themes as well, making this the central theme. The second theme was Quality of Life, which consisted of the sub themes: 'ideal' and 'actual'. This predominantly captured the differences between reality and what is doable versus ideally the way they would like it to be. The third theme was Lifestyle, which consisted of the sub-themes of: 'dietary'; 'physical activity'; 'physical health'; and 'psychological and emotional well-being'. This theme identified the sub-themes to be significant factors in developing and or maintaining a healthier lifestyle.

The fourth theme was Service Delivery Model, which consisted of the sub-themes: 'structure'; 'government'; 'role of counselling psychology'; and 'limitations'. This

theme focused on the organisational structures used within such programmes and the limitations experienced. The fifth theme was Professional versus Personal beliefs and values, which consisted of the sub-themes: 'professionals' experiences' and 'personal experiences'. This captured the individuals views on what contributed to successful weight loss and the barriers encountered. These main themes have been illustrated in Figure 3.1.followed by detailed accounts of them in the Results and Discussion section, especially in section 3.6.

During data collection there was a period in between the professional and patient interviews, where the professional interviews were analysed to ascertain whether any questions for the patient interviews needed amending before collating the patient data. This was to aid the iterative process to reach optimal rich data as possible.

To enhance dependability and validity of the themes, they were discussed to an extent with a fellow student as well as the researchers' university supervisors, in order to establish that any significant codes forming sub-themes linking to main themes and overall linking to other main themes had not been overlooked or thought about fully. On reflection after processing some of the discussions had, this led to some refining of the themes, for example 'Tension' was found to be a central theme inter-linking to all other four main themes found.

2.6. Ethical Considerations

With reference to the British Psychological Society's (2010) code of ethics and conduct, areas of consideration would include informed consent, therefore an

Information Sheet was provided to explain clearly the nature of the study, so that the participant could make an informed decision as to whether to take part.

A consent form was given to the participant to read and sign. They were also informed that they could withdraw at any stage up to three weeks after the interview had taken place, as transcription would start after this. If the participant did decide to withdraw then it would be made clear that any recordings the researcher would hold for them would be destroyed and at no stage would their treatment with weight management services be influenced.

Participants were debriefed and they were provided with details of the researcher, study supervisor (s) and any other relevant professionals deemed necessary. The researcher was available to answer any questions the participant may have had about the study. Risk of any psychological harm or distress that may occur when participating in this study would be kept to a minimum. If this did occur then appropriate guidance for professional contacts would be given. All the data including audio recordings had been kept confidential. It was explained to the participants that the data would be anonymised, and the participants' names in the data would be replaced with Pseudonyms. The raw data would be kept in a safe lockable place, where it would only be accessed by those who are part of the study team. The researcher had made sure any information that may lead to identification of an individual had been removed from the transcripts.

2.6.1. Quality of the research

In this study interviews were conducted, and TA was conducted with the aid of field notes, as well as research supervision to reflect and be challenged on ideas in relation to the interpretations made of the data, especially as the researcher was drawing information from both users of an information service and professionals who delivered it.

In view of exploring transferability; Meriam (1998) states that external validity "is concerned with the extent to which the findings of one study can be applied to other situations". In positivist work, usually the results can be applied to a wider population. Since the findings of a qualitative project are specific to a small number of participants and particular environments, it is impossible to demonstrate the findings and conclusions that are applicable to other situations and populations. This is reflective of the present research too. Although, Bassey (1981) suggested that if practitioners believe their situations to be similar to the study described, then they may relate the findings to their own positions. It should be questioned whether the notion of producing truly transferable results from a single study is a realistic aim or whether it disregards the importance of context which forms a significant factor in qualitative research (Shenton, 2004). In context of the present research it would be difficult to replicate the exact same results due to the themes being based on individual accounts and analyses conducted by different researchers, but nevertheless overall themes may reflect themes from the current research.

Silverman (2000) considered that if the researcher can relate their findings to an existing body of knowledge, it is a key criterion for evaluating works of qualitative

inquiry; this is reflective of the present research as the findings are discussed in the next chapter.

Overall, there are improvements that could be made to the credibility of this research, especially as qualitative research is usually open more to subjectivity. Compromises made during interviews, for example, interviewing in different environments i.e. patients home, NHS setting may have led to differences in participant responses according to how much at ease they felt in these different environments.

The following section discusses the central theme along with the four main themes in detail as well as relevant discussion generated.

Chapter 3- Results and Discussion

The four main themes with the central theme of 'Tensions' has been illustrated below (also see Appendix 10).

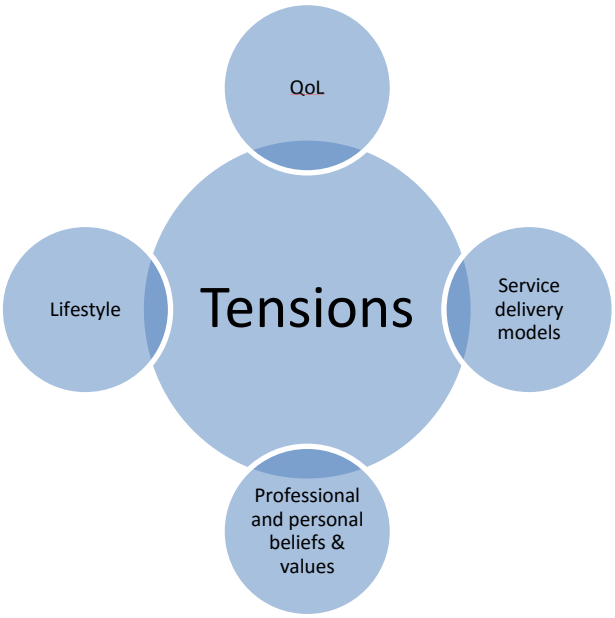


Figure 3.1 [Tensions in weight management]

The analysis is presented in light of the emergent themes from the discussions with patients and practitioners. The analysis had synthesised findings across the professional and patient perspectives, but also presented these groups separately where divergent findings emerged. The patients in this study were not seen by the psychologist in the weight management service, therefore their perceptions of psychology were not reflective of the health psychologist interviewed for this study. With Tension being pivotal to all main and sub themes and inter-connecting with all of the four main themes, the importance of these themes have been ranked as:

Tension; QoL; Lifestyle; Service Delivery Model; and Personal versus Professional beliefs and values.

3.1. Main theme one: Tension

This theme looked at some of the difficulties experienced by both professionals and patients in delivering and receiving a service respectively.

3.1.1. Professionals

There were frustrations about how difficult it can be to encourage patients to access psychological support, Kate said:

> '*so there's certainly people that I've offered it to who try to sort've convince them that it might be worth their time to least have an initial appointment. But you get people who say well I'm not coming back for something else. You know not interested the word psychology can be quite scary for some people' (L31-35).*

Dave had also noticed patient reluctance in accessing psychological support, '*and thought they could probably do with some psychological input umm you ask them and they say ooh not at the minute yeah 'n' obviously we sort've re-visit that at different stages' (L48-50).* It is understandable that if their efforts are not well received by the professional, this has potential to generate frustration and tensions in the relationship.

Kate and Dave both mention how the word 'psychology' can be scary for patients; making it harder for the practitioners to encourage access to the service. Based on

their roles in the programme these practitioners initially meet with patients starting the programme, and they also sign post to different services where appropriate. The difficulty of encouraging quite reluctant patients seemed apparent. Patients were described by practitioners as they just wanted to attend the core parts of the programme, or not being prepared to consider other services, for example psychology, due to the lack of understanding regarding psychological support. This can raise issues of patient willingness and engagement. This could also be viewed as they want a 'quick fix' and or that they are not particularly committed to losing weight. This could then lead to stereotyping obese individuals and room for stigma as discussed earlier in section 1.6.1. It also highlighted the importance of educating patients about MDT working as outlined in the Literature Review and having an understanding of the role of psychology within this, thereby making it easier for professionals to explain the role to patients.

Once patients understood psychology to be an optional part of the programme, this can make a huge difference to the number of patients who access these services, as some will opt out without giving it full consideration, again possibly due to the lack of understanding. There may be an improved message that could be given from professionals as to how they convey these messages about the optional parts of the programme. It is fair to acknowledge that patients are more likely to attend if they knew that by not attending psychology would have an impact on them being able to attend the programme; *'you always get the people who put their foot down 'n' say I don't wana try I'm not interested I'm coming in for this that's enough' (*Kate *L37-39)* and as Dave pointed out, *'why they don't I'm not really sure. But it is clear in some cases that you know they probably would've benefitted from some input' (L51-52).* It

would have been interesting as to how they would have responded if they were told psychology or other optional services were compulsory.

In a study by Apovian, Garvey and Ryan (2015), as mentioned earlier, comprehensive lifestyle management was the main intervention in treating adult obesity. They stated that behavioural intervention was an essential aspect of this lifestyle management promoting weight loss, as it provided patients with strategies. The American Medical Association (2015) also emphasised the importance of a comprehensive lifestyle management to the treatment of obesity. Practitioners appear to be supporting this, as they are advocating psychological support. From a practitioner perspective this may question how motivated obese patients are about managing their weight, when they are not willing to access support from psychological services offered. Whereas, from a patient perspective they may be room for improvement in how psychological services are explained to them.

Tensions were also identified within the service of what a professional would like to offer, versus the constraints imposed by the service specification:

> '*I can't really do much with them because I don't see them often enough to actually engage with them on the level where we can go into any kind of psychological problems' (*Amy *L29-31) […] 'I find it quite difficult to do good work with them, because I don't get enough time with them to do the work, and the sessions aren't very long, I only get 20 minutes with them per session' (Amy L35-37).*

Similarly, for Jim the frustrations and tensions were apparent because of the gap between the service he can offer as a medical doctor and what input (or support) patients wanted:

> *' if I have a patient who is overweight but is relatively well, then the range of medicines I can give them to help is very limited because a lot patients don't want medicines, and that makes my role much less than the other members of the MDT' (Jim L52-55).*

This challenged his role, job satisfaction and input within a weight management programme. Power and status type factors within professionals will be discussed in section 4.1.3. with studies, for example, Robinson and Cottrell (2005).

3.1.2. Patients

It was apparent from interviewing patients who accessed weight management services, that they were referred as a result of attending another service for their physical health problems. This clearly indicated that they did not refer themselves through their GP, which may also have indicated that they may not have viewed their weight as a problem. It was interesting that for all patients interviewed this was the case, as opposed to obesity being identified earlier, in Primary care and the patient referred through their GP or Practice Nurse. This highlighted a significant and contemporary point regarding integrated care and contributing to service development.

Blount (2003) reviewed literature and found collaborative care has been shown to be predictably effective if the type of relationship between mental health and medical

providers, the population served and the type of service provided are adequately specified. The types of outcomes that can be demonstrated are predictable and descriptions of collaborative or integrated care are more specific to avoid confusion. Blount (2003) stated that the need to broaden the array of outcomes reported in any literature about collaborative care is important. This will make it easier to discuss the utility of this sort of care with the varied constituencies that have an interest in it.

Gill was made aware of the weight management service through her Myalgic Encephalopathy (ME) support group, Barbara was referred through the Chronic Obstructive Pulmonary team, Ella was referred by the cardiac team, and Bob by the smoking cessation team. The researcher speculated that maybe if these patients had been referred to manage their weight earlier on, it may have had a positive impact on their health problems, leading to less distress and difficulties in their lives and impacting positively upon their QoL. This has been illustrated somewhat below where patients described experiencing events and this prompted them to make lifestyle changes.

For example, Ella discussed how she had a heart attack, which then had encouraged her to lose weight and attend the programme:

> *'once I went back to heart care after this…heart attack, I really needed to do because…..I've had someone tell me, part of the…heart team…..I needed to change my lifestyle otherwise...I wasn't gonna die but things were gonna get really bad so I decided I was going to do something about….I know I should have done something, well I've been dieting on and off for years but never,*

not really...taking much notice…..I've only got one heart so, I know it's a big deal now' (Ella L11-18).

Ella takes responsibility that she should have sought help sooner regarding weight loss. For others there were tensions and feelings of being let down towards health practitioners regarding awareness of health related issues. For Gill tensions were due to not receiving support at the time of need, *'you need the help when you need it. You don't need it sort of years later. So I would have preferred it, you know, 7 years ago or something like that' (L115-117).*

Professionals and patients experienced tensions with weight loss services (WLS) in different ways. Professionals seemed more concerned with overcoming patients' reluctance to access services whilst patient frustrations were more focused on receiving services at the right time. This corroborates the practitioners' view to a degree as they stated they would like to do more to help, but are constrained by what is permitted by the service framework. Although it could be apparent that patients are lacking in motivation in attending services when offered and the frustration this may evoke within professionals but it could also be as shown in the excerpt above, the lack of services and near desperation for support being unavailable.

3.2. Main theme two: Quality of Life (QoL)

QoL refers to all the factors the participants identified as important in supporting a more satisfying and fulfilling way of living and the role of weight loss in achieving life

satisfaction. The data suggested a contrast between the 'ideal quality of life' versus the 'actual quality of life'.

Subthemes: *Ideal and Actual.*

3.2.1. Ideal

This subtheme described the constituents of an 'ideal' life; defined by participants' life, free from all problems and with a valued QoL.

3.2.1.1. Professionals

Amy's general viewpoint seemed rather ideal, as she felt that a patient needed to be motivated and intentionally focused on making changes implying that if they didn't then they would struggle to be successful in losing weight:

> *'the motivation has to be at the right mind-set (L98) […] ready to engage (Amy L106) […] looking at self-esteem and how people feel about themselves […] looking at their mood' (Amy L113-114).*

Further to this Dave also felt that a positive way of thinking and lifestyle would really support weight loss*: 'changing […] perception […] rather than using food as an emotional support' (L154-156), 'a lot of focus 'n' effort' (L161), 'lifestyle modification' (L165), 'motivation is a big factor' (L169).*

Whereas, Diane discussed her perceived 'ideal patient' for a weight loss programme, who would successfully lose weight and experience a positive impact on their QoL. She identified characteristics such as*,' determination', 'open-minded' (L149), 'willing*

to change' (L151), 'willing to able to plan' (L154), and 'willing to make those changes' (L156-7).

3.2.1.2. Patients

Gill's ideal of her QoL was a hope and passion to live a richer life in comparison to the life she feels she has at present. Her enthusiasm to achieve this ideal life was evident from her facial expressions as she spoke*:*

> *'if I was healthy […] then obviously the world's your oyster isn't it? You're in control of your own life and you can do what you want to do can't you? [...] general feeling of well-being and contentness […] you'd be working, you'd have money, you'd be having fun, you'd be exercising, you'd be eating healthily, you'd be erm […] going on holiday and all sorts of nice things like that and actually sleeping which is something that is a problem with ME people as well, 'cos you don't have refreshing sleeps, so you wake up feeling as bad as when you've gone to bed, so it would be nice!' (Gill L279-295).*

Being in control was an important dimension of QoL to Gill; this may reflect a feeling that she has little control over her ME and or her weight loss. It is possible that prior to developing ME and weight difficulties she may have felt quite autonomous and has had to make significant changes to accommodate the changes in her health status. She was someone who felt if she had received a service earlier she may not have put as much weight on, hence impacting on her quality of life. But at the time she did not qualify for the weight management programme. Weight can be a barrier to many factors including: employment; increased finances; holidays; and exercise. Gill may be using weight difficulties as a protective mechanism for improving her

QoL as a reduced QoL may give her permission to be in a victim role or feel life is unfair.

Bob discussed QoL in terms of enjoying life and this illustrated his ideal view of QoL, *'being able to do the things I like doing you know […] enjoying life […] not feeling down and negative about everything. You know and just basically enjoying life' (L965-967).* Bob discussed emotional wellbeing as well as physical. Further to this Barbara's good QoL included the well-being of her family too, *'I'm, my family's healthy, I'm reasonably healthy and I can do the things I want to, I'm happy' (L546-547).*

3.2.2. Actual

This referred to the 'actual' life that they have with the problems they may be facing and managing on a daily basis, hence impacting on the level of their QoL.

3.2.2.1. Professionals

Amy was aware of how obstacles can impinge upon a good QoL, for example, depression, could impact on how well one does with their weight loss:

> *'if I can see depression there, or causing them to overeat […] that's causing them depression, the eating might go hand in hand with that one so that's something to look at' (Amy L115-118).*

Here, Amy was aware that in actual fact there could be significant factors affecting an individuals' motivation and their intentions to make change, as she acknowledged

that if they are low in mood then they may not engage well. Diane's reference earlier to an ideal patient also mentioned factors such as intentions and willingness to change and consequently having a positive impact upon their QoL. Ways of increasing motivation and readiness to change in obese individuals was a potential area for professionals to address. This could also have an impact on addressing the gap identified between the 'ideal' and 'actual' QoL. This also illustrated why one 'size fits all' as a model would not be successful.

Dave was realistically aware of some of the external difficulties faced including*: 'education' (L141), existing 'family traits […] always been big eaters' (L144) 'they find it hard to break the cycle' (L145), and 'sometimes partners […] are sort've feeders' (L146-147).* Dave also discussed how hard health related issues can make it for an individual to realistically try and lose weight:

> *'You know what their motivations are what their targets are […] what their chances are where […] some of the people who we see […] got mobility issues, multiple co-morbidities […] even if they made food changes […] you think it's going to be hard for them' (Dave L190-194).*

The researcher noticed that there was definitely empathy present within professionals whilst understanding the constraints some of these patients may encounter, especially with health difficulties. This may also lead to professional tensions and frustrations of trying to support such people who then struggled to meet the goals on the programme. Indicators of increasing patient engagement and motivation with obese individuals could include: focus; effort; and lifestyle modification.

3.2.2.2. Patients

Gill was appreciative of the smaller things in her life and used them to define her realistic QoL*;*

> *'I've got to try and make the most of what I have got so I do try and do the positive […] even if it's only looking at a nice blue sky or a nice cup of tea or whatever […] I have to try and make my kind of world goals pretty darn small' (Gill L275-278).*

It was apparent that she had to make changes and adjusted to making very small goals due to her health. Although she was accepting of this, it was obvious she was not very happy about making such significant changes in her life*, 'Well I've had to lower my standards so basically it's surviving the day' (L297).* This can lead to frustration and tension arising from the gap between what she would like to do versus what she can do, and potentially not being able to complete a weight loss programme the way she would have liked to. Maybe if she felt more motivated this could have improved her weight loss progress. Motivation and readiness for change was mentioned earlier as a potential identifiable gap, but with obese individuals it may be the difference between those who manage to lose weight versus those who struggle.

Bob kept his understanding of what constituted a good QoL predominantly on a personal level. His main focus was managing his pain levels, *'I need to maintain pain problems to be honest' (L976-977).* Oster, Harding, Dukes, Edelsberg and Cleary (2005), reported that many older persons (age > 65 years) with post-therapeutic

neuralgia experienced longstanding, severe, and debilitating pain, resulting in poor health-related quality of life as well as levels of dissatisfaction with treatment being high. This highlighted the impact pain can have upon QoL.

Bob combined realistic and idealistic QoL, by managing his health, so that he is able to do what he would like to which in turn is likely to have a positive impact upon his mood:

> *'if I can get up on a daily basis and pain's not too bad and I'm able to manage it painkillers whatever, generally I can have a good day you know I mean I'd be positive. I can't do everything I want to do' (Bob L999-1001).*

This is an example, of where health difficulties can be managed and a good QoL is still possible which can include managing weight loss well. The combination of idealistic and realistic QoL is reflected in Barbara's interview too*: 'being able to walk out into the country' (L552), 'We caravan a lot […] we go off in that, for a month at a time if we want to' (L556-557).* With Bob and Barbara there is probably a part of them being able to do what they would like to as a result of feeling motivated to making these life changes. A significant finding regarding motivation with weight loss programmes was found by Williams, Grow, Freedman, Ryan, and Deci (1996), which showed that participants whose motivation for weight loss was more autonomous would attend the program more regularly, lose more weight during the program, and evidenced greater maintenance in weight loss.

It is interesting that most patients focused on physical health when considering QoL, their physical health status was clearly noticeable. It was also interesting to hear

from Gill questioning whether QoL was being defined in terms of a person with health difficulties or not, *'for a fictitious person or an ME person' (L272).* Defining QoL was a significant issue with all patient participants. It would have been interesting if any of the participants did not have any physical health problems to see what their focus in QoL goals may have been, and how it may have differed. This idea is also indicative of the literature in this area too, in that there is a lot of research available on health related QoL (HRQoL) in contrast to QoL alone. Obesity has been found to have a considerable impact on HRQoL (see for example, Jia and Lubetkin, 2010). From a patient perspective, an increase in HRQoL is most likely the important outcome of the weight reducing procedure (referring to Bariatric Surgery), and in fact, there has been an increase in the number of studies measuring HRQoL in the last years (see, for example, Sockalingam, Wnuk, Strimas, Hawa, and Okrainec, 2011).

3.3. Main theme three: Lifestyle

Lifestyle included: attitudes; values; beliefs; habits; or possessions associated with an individual. This may also include the requirements of a desirable lifestyle. The sub-themes below are a reflection of the collective factors identified within the data found attributing to this main theme.

Sub themes- Dietary, Physical activity, Physical health, Psychological well-being.

3.3.1. Dietary

3.3.1.1. Professionals

This theme was concerned with the healthy eating advice and support offered by professionals involved in the weight management programme. In their professional roles both Kate and Dave are most likely to be providing any dietary advice given.

Kate discussed how patient attitudes and previous experiences of dieting can have an impact on their success in the programme:

> '*Problem is a lot of people done a lot before; weight watchers, slimming world or these weight loss programmes and are very negative towards that type of thing. I think they come in and expect this to be exactly the same and I hope that it will be what works for them' (Kate L174-178).*

This could create frustrations for Kate when she is faced with patients who think this programme is the same as other diets they have completed, being purely nutritional; as she is aware their programme has a more holistic approach. This is discussed at the end of this main theme.

Dave explained his role in relation to offering dietary advice*, 'my role is to meet with the client once a week for twelve weeks where we give dietary and lifestyle advice and set them a sort of patient plan and obviously set them weight loss targets and encourage them to stick to those and hopefully lose weight' (L6-9).* Both Dave and Kate are at the forefront of this programme regarding lifestyle advice.

3.3.1.2. Patients

This sub theme identified how patients showed receptive and openness to learning and how they used this learning to make changes in response to the dietary advice they had received.

Gill talks about the usefulness of the dieticians' role to her:

> '*I still see Jo every couple of months so it'll just be on-going (L36) […] 'I think it's helpful seeing Jo sort of monthly or bi-monthly or something, cos it sort of keeps it on the agenda and if you want to ask something or know, or want to go down a different avenue and think about something, you've got somebody there' (Gill L104-106).*

Gill stated the importance of the dietician and more importantly that her input is valued! This highlighted the role of regular contact and Gill could be viewing this as social support too.

In contrast, Bob's wife cooks for him and he does not always feel free to eat what he would like to as he feels obliged to eat what has been cooked for him. The result is that, he then does not feel in control of his weight loss. He expressed this by saying:

> *'I mean she tries her very best, but I mean like, I'm not keen on meat now you know and I say like 'Don't give me meat' (L891-892),'I shouldn't eat too much meat but then I get given a lot meat and I mean, what do I do, do I eat it or do I not eat it and have an argument. So a bit of a battle with myself to be honest' (L896-898).*

Food symbolised care via nurturance, and eating food prepared specifically for an individual is a very important dimension of exchanges of care in an intimate relationship. Bob rejecting his wife's food would possibly feel as if he was rejecting his wife. These tacit pressures to eat are very influential and not always easy to understand. The beliefs, habits and values of family members and compulsion of individuals can sometimes prove to be unhelpful with weight loss regimes which have been mentioned by professionals earlier.

3.3.2. Physical activity

3.3.2.1. Professionals

This referred to the exercise advice offered by the professionals and commitment required from the patients to benefit from this aspect of the programme. This is to aid their weight loss as well as contributing to improving their health. Similar to the dietary theme, exercise advice is also predominantly offered by Dave and Kate.

Dave talked about the importance of exercise and the health related benefits:

> *'some of them are achieving 20-30% body weight, weight loss, improvements in the other indicators blood pressure, cholesterol, blood sugar. Quite a few that have lost sort of you know 4 or 5 stone and a lot of them have fit that sort of age and gender category really. Going on from that those are the ones that have committed to the exercise. So they have attended regularly for their weight management consultations and also they use the gym frequently which comes as part of the service as well' (Dave L114-121).*

He emphasised the importance of using the gym alongside attending the weight management consultations regularly. The difficulties with using the gym and exercising can be when patients' ill health makes it difficult for them to use this optimally. This is discussed further in section 3.3.3.

Dave emphasised the importance of making a commitment; to a weight management programme, exercising and using the gym regularly. Kate discussed what could be viewed as potential frustrations and tensions when advice is not taken seriously:

> *'someone who is having 12 takeaways in a week 'n' not doing any exercise 'n' I'm gona ask them to cut out the takeaways 'n' come 'n' use the gym free' (Kate L294-296).*

As discussed in Section 3.1, this affirmed that if advice is not followed then it makes it harder for professionals to work with patients trying to lose weight. But from a professional perspective it could also be an easier way of understanding when weight loss progress is not being achieved by blaming the patient, in that they are not being compliant and adhering well to the adjustments.

Miller, Hill, Kottke and Ockene (1997), stated that although patients must accept ultimate responsibility for making behavioural changes, adherence is also affected by knowledge, attitudes, skills, the environment, the health care providers' practices, as well as the health care system. The multidisciplinary team providing a form of social support (Ockene and Ockene, 1992) plays an important role in influencing adherence behaviours (Higgins, Budney, Bickel, Foerg, Donham and Badger, 1994; Kulik and Mahler 1993) and patient satisfaction with care are significant predictors of

adherence to following regimes (Sherbourne, Hays, Ordway, DiMatteo and Kravitz, 1992).

Further to this Miller, Hill, Kottke and Ockene (1997), stated that tackling the issue of adherence is not just restricted to the patient or the provider level alone, but a successful outcome is likely to occur when the entire framework within provider–patient interaction takes place. Koeck (1998) summarised well that, "if care is to be of higher quality and lower cost, the key to improvement lies in better organisational structures and processes" (p1267). Another approach to tackling adherence could be utilising the support of a counselling psychologist in using conceptual theories and health behaviour change models in managing adherence better as well as being trainers of other health care providers. This will be discussed further in sections 4.1.1. and 4.1.3.

3.3.2.2. Patients

This addressed the exercise advice that was received as part of their weight loss programme. A common viewpoint was that when there were significant health problems, it made it a lot harder to exercise and receive maximum benefit from a weight loss programme. Bob discussed his view point of the commitment needed to make exercising beneficial for oneself:

> *'to discipline myself (L524), 'exercise I'm not too bad to be fair. I mean, I can, you know I can do that as best as I can, I mean I've asked for more exercise today to be fair (L528-529),' I try and push myself you know what I mean' (Bob L533).*

Barbara discussed how exercise has been beneficial for her health, regardless of having chronic health difficulties:

> *'through having lost all this weight. The exercises which I'm doing as well have helped me with my breathing (L238-239),'I felt so much better after the COPD part doing, starting the exercises, I felt so much better that I thought losing weight can only make it even better still' (Barbara L283-285).*

These are both good examples, of where despite health difficulties exercise can be attempted and positive effects taken from it. This supported the research mentioned earlier by Miller, Hill, Kottke and Ockene (1997), regarding that the ultimate responsibility lies with the individual, which is apparent here. There could also be factors like motivation and readiness for change contributing to making and sustaining lifestyle changes. This is supported by Williams, Grow, Freedman, Ryan, and Deci (1996) as discussed earlier.

3.3.3. Physical Health

3.3.3.1. Professionals

The professionals were aware of the constraints that health problems can impose for someone trying to lose weight and improve fitness when they struggle to exercise. They expressed understanding that this is a problem and not just the patient being awkward which as discussed earlier gives rise to the patient being potentially blamed for not complying with the programme. Dave expressed his understanding by saying:

> '*we've been working in it for a long time so you understand that it's not just that they not doing enough and they are eating too much, there are sort of*

other health issues that can affect it and obviously the mobility is a big factor within that as well' (Dave L95-98).

He discussed how it is not just the barriers of not exercising enough and eating too much but also health difficulties including mobility being important factors in contributing to losing weight. This showed the other side to professionals who may question how compliant or willing an obese individual is to losing weight.

An interesting discussion led by Jim indicated that patients who came to see him were more interested in their self-image as opposed to the improvement of their health difficulties:

'their perceptions about success are different because, let's be honest, it's all to do with body shape, it's all to do with self-image, even my patients with multiple comorbidities will say, it's all to do with self-image' (Jim L451-453).

This contrasted with the patient perspective discussed earlier that stated one of the main reasons for attempting to lose weight was to help their physical health.

3.3.3.2. Patients

Patients' shared a viewpoint about the impact of significant health difficulties when trying to lose weight.

Gill discussed her health difficulties and how this can stop her from exercising the way she would like to or has been advised to:

> *'I don't think people sort of realise quite how bad like the ME actually was' (L143), 'you know, debilitating it actually is' (L147),'most people you'd sort of say well, you know, go and exercise and you know, if obviously we can't really kind of do, so in an ideal world, somebody that specialises in ME [...] that also specialises in the diet would be wonderful but it's not likely to happen' (Gill L149-152).*

Gill seemed interested in seeing someone who is a specialist in ME and can support her in weight loss as opposed to a generic weight loss programme. Further to this Ella also supported the notion that losing weight was more about her health than her self-image, '*it's my heart now (L63),* 'h*ealth related more than just looks related' (L67).* This once again contrasted with Dave's view on the main drive for obese individuals losing weight.

This subtheme acknowledged how weight loss programmes can help those struggling with co-morbidities too.

3.3.4. Psychological and emotional well-being

3.3.4.1. Professionals

There was a shared understanding of the impact of readiness to change and engage in support as well emotional eating having a huge impact upon managing weight loss.

Amy discussed psychological issues that she had noticed that would impact upon weight loss and the importance of being ready to make changes:

> *'there was quite a lot people identified around a lot of anxiety, stress management problems, lack of motivation […] self-esteem' (L46-49), 'some people are very resistant they are not really ready to engage so I guess the readiness will change' (Amy L106-107).*

Kate furthered this by talking about where psychology could be involved with obese patients:

> *'you know emotional eating and boredom eating things that been able to delve that little bit deeper. You know I can say to someone when you're bored you go to the kitchen cupboard and having a biscuit but having somebody there that can look a bit further into that to break that link, is obviously what I am not there to do. That support to do that certainly is part of that' (Kate L272-276).*

It is reassuring to see that Kate was aware of what psychological support can be used for! She highlighted the problem of emotional eating, boredom and a gap in services where she does not feel capable of dealing with this issue. This emphasised the importance of psychological involvement, to the extent that a psychologist could train and or provide regular clinical supervision to support and increase Kate's confidence to address such issues.

From a different perspective Jim discussed how psychology can be under-used when patients are reluctant to admit and ask for help*:*

> *'they feel ashamed, they feel they should be able to cope themselves, they*

feel that people won't be able to understand, or people won't be able to help. If they perceive their particular problem is atypical, then from our point of view, it may not be atypical, it may be absolutely common place' (Jim L117-120).

From a professional perspective it seemed that Dave was finding it difficult to understand the reasoning behind the patients' reluctance to access psychological support. In general, this is not uncommon for those who are reluctant to access psychological support, as accessing support may make them feel weak and incompetent to cope.

3.3.4.2. Patients

Overall patients identified with how their mood impacted on their motivation to lose weight.

Bob discussed when he is in pain this determines his mood and the rest of the day:

'If I can get up on a daily basis and pain's not too bad and I'm able to manage it painkillers whatever, generally I can have a good day you know I mean I'd be positive (L999-1001), 'if I'm in real bad pain and I get down, it brings me down pretty quick, I'll not go out at all' (L1018-1019), '*I'll not do anything. You know, I'll probably stay in bed possibly (L1023),* '*it really affects me to be honest with you' (L1027)*, *I mean I can work on how I feel, with me moods and what have you. But I mean some days I just can't do anything about the physical problems' (Bob L1039-1041).*

Here, Bob shared an example of his physical and emotional health impacting upon his daily activities. This can also impact on how well he can manage the weight loss programme too. Although he feels he can manage his moods better but feels out of control about days when he cannot manage his physical health, which as a vicious cycle is likely to impact upon his mood.

Whereas Barbara's view of psychology was very much that she did not need it as it was common sense to her:

> '*Cos I didn't think it, to me it's just common sense' (L114)*. *'I mean I've dieted before years and years ago and managed to lose weight and of course as I've got older I've put it back on again' (Barbara L118-119).*

It seemed that Barbara had enough self-confidence, in that she had lost weight before so she could lose it again and hence did not need any support in that respect. This had been discussed earlier in Gupta (2014), where self-confidence was found as a contributory factor to sustaining long term weight loss. Self-efficacy had been mentioned in the NICE guidelines (2007) earlier, where PDG acknowledged this as a contributory factor to an individuals' well-being. Therefore good self-efficacy is important in managing life difficulties well.

The findings suggested that there were differing views between professionals and patients' with the reasons for losing weight. Dave (professional) felt body image was more important for patients whereas of the four patients interviewed they all seemed to want to lose weight for their health. Professionals understood patients' health difficulties that can impact on weight loss progress, especially with exercising. There

was literature mentioned regarding the importance of the patient taking responsibility for their weight loss, which was found in this data but also that professionals and the wider system also have a role to fulfil. This can indicate if stigma was apparent from professionals then this could impact on the progress a patient may achieve.

Overall, lifestyle has an important role in weight loss, as established in the literature review and the findings seem to affirm the connection. There are various studies that emphasised the importance of lifestyle within managing obesity, for example, Apovian, Garvey and Ryan (2015) found a comprehensive lifestyle management is the core intervention for the treatment of adult obesity. The importance of all aspects of an individuals' lifestyle and the impact this has upon their weight loss success. This is reflected in the current weight management programme offered, as Kate stated:

> '*the opportunity to have the psychological side of it, the opportunity to have a doctors support, specifically for weight management […] particularly for our […] place running exercise and healthy lifestyle […] all in one go really, so you know in terms of what we do I think it's [...] all there' (Kate L348-352).*

3.4. Main theme four: Service Delivery Model

Weight management referred to weight loss programmes; this included the way such programmes are promoted, the different health professionals involved and the level of support offered locally as well as nationally and the limitations that are apparent.

Sub themes- Structure, Government, Role of a Counselling Psychologist and Limitations.

3.4.1. Structure

3.4.1.1. Professionals

The professionals placed emphasis on lifestyle modification as opposed to a weight loss regime. The structure of the programme benefits from providing a number of services in conjunction with each other and the impact this can have with patients' lives in different ways. There is a national emphasis on Key Performance Indicators (KPI's) and set weight loss targets to adhere to.

Dave discussed how individuals are set the 5-10% weight loss target:

> '*We approach each case on an individual basis but we tend to set them weight loss targets, five and ten percent. Five percent at 12 weeks and ten percent at 24 weeks (L66-69),* '*obviously areas that they can target to try and improve, you know some people they don't eat breakfast or they don't eat for long periods of time. You know they will eat late at night some snack or lots of different things so it's just looking at those and trying to improve it and brings it into targets of the key performance indicators we got on fruit and veg, physical activity and we also look at the blood pressure, cholesterol, blood glucose, try and get improvements in all of those areas as well' (Dave L83-90)*

Dave focused on the improvements in lifestyle needed to help meet the targets set. This takes the weight management programme away from a generic nutrition based diet to an adaption of a healthier lifestyle, which would result in a positive impact on physical health. This may raise the issue that if there was not a measurable set

target applied then how would weight loss be reported, especially when averages of a cohort of people may have to be reported back to senior management that could determine funding for the programme to continue. The set targets could be viewed as measures for motivation for individuals to lose weight, although it applies a pressure of how much qualifies as weight loss achieved!

Diane stated that difficulties of being on a referral pathway and how this can mean patients are referred in, who may not be ready to make that commitment:

> *'that because we are now on a referral pathway so people are referred in, and although we say they need to be motivated, you still get people from the GPs passing people through that probably aren't ready […] they aren't going to do as well because they're still not in the right place so I think whatever you put in, that patient's still got to be ready to lose weight and I think a lot of them, the ones that do well, I think sort of they have got it in their mind that they really want to do well, and they will work at everything that is given to them' (L60-66), 'weren't aware of what they were eating so what they sort of saw as the norm, wasn't at all, so a lot of it was about re-education […] and that they haven't had that information to start with' (Diane L67-71).*

Diane illustrated that with some individuals it is about re-education about lifestyle changes that they may never have been informed about. The referral pathway criteria could create tension for all professionals involved, especially if they have to work with patients who are not ready to engage. Consequently, this would have an impact on the results reported especially that of meeting the predefined targets. A part of this tension could also be if their patients are not meeting the set targets. This

may show the professionals and the wider service as providing a poor or failing service.

3.4.1.2. Patients

Like the professionals' perspective there seems to be an agreement on having a number of services together and the usefulness of this. There were reservations shared of the criteria to qualify for such a programme as well as emphasising the importance of on-going support.

Gill discussed the impact of the qualifying criteria for such weight management programmes:

> *'I've been ill 17 years and I knew I needed to lose weight and I desperately wanted to see a dietician for years and years, but they wouldn't see me because my BMI wasn't over 30' (L107-109), I had to wait until I got fatter to actually get the help' (Gill L111)*

It was understandable that Gill's mood could have been affected as a result of having to wait longer, as well as waiting for her weight to increase before she was allowed to access a service. This could then consequently lead to not just deterioration in physical health but mental health too.

Bob emphasised the importance of a combination of things in a weight management programme to support weight loss, *'I think there's a bit of a combination of losing*

weight, getting fitter and healthier to be honest' (L62-63). He goes on to suggest that he should have indefinite access to the programme*, 'indefinitely for me, the way I am, do you know what I'm saying? I need to definitely keep coming to the gym' (L329-330).* This highlighted the importance of on-going support, especially in sustaining weight loss. This has been discussed in section 1.5.4.

3.4.2. Government

3.4.2.1. Professionals

Practitioners emphasised their frustrations with set predefined targets as well as the fairness of the system including lack of resources i.e. psychological support.

Diane suggested that there is a difference between a target given and other means of achieved weight loss:

> *'what we are **given** to define what is successful, so anything that is between 5 and 10% is deemed as successful' (L79-80),'looking at all the information, have lost quite a lot in girth but may not have lost as much from the weight point of view' (Diane L82-83)*

Diane's frustrations of the given definition to weight loss seemed rather apparent. She mentioned that some may not meet the predefined success rate set, but have managed to lose it in girth. This then raised the question as to why girth and waist circumference are not part of the predefined success for weight loss criteria. This is discussed further in section 3.4.4.

Jim discussed the inequality in the wider system for treatment as well as the frustrations with vagueness presented with NICE guidelines, especially regarding psychological input:

> *'you can have 2 patients sent to you in the same clinic, who are exactly identical but one will qualify for surgery, the other won't, because of their […] criteria and their different health authorities and that is completely wrong, but that's just how it works (L 548-551), 'so it says the MDT must include a psychologist. But what does that mean? Is it a psychologist once a week, once a month? And what does that psychologist do? Do they see all patients? Just see a few patients? (L590-592),' that doesn't help the service because we genuinely believe we want more and more psychological input, but because NICE can't define that' (L593-594),' in a world of limited resource, people who commission services (L595)', 'will get away with the minimum, we've got to have a psychologist' (Jim L596)*

Jim's frustrations for the differences in health authorities and what determines a service seemed apparent, but also suggested that there are gaps in the equality of treatments offered in the NHS. He also questioned the inadequate guidance provided by NICE, especially regarding psychology in weight management services. This may give rise to why psychology is not more heavily involved in such services. Another factor that cannot be overlooked is the current economic climate and how improved cost efficiency is at the fore-front for commissioners.

3.4.2.2. Patients

This perspective addressed the difficulty of accessing or at least being made aware of weight management programmes.

Gill was a good example of someone who had been ill for 17 years and had to wait seven years to meet the qualifying criteria to access a weight management service and in the interim continued to put weight on, which may have had consequences for her physical and mental health. This has been discussed in section 3.4.4.

Bob discussed his view on the negativity attached as well as portrayed about obese people:

> *'Cos everybody's negative like about people being overweight now, I mean, social media and all that, people are attacking it all the time (L788-789), 'this is your punishment now' (L793), 'You've got yourself in this state, you're a burden to the National Health, you know' (L797-798),'I see some negative stuff out there to be honest with you. You know, people who've got agendas and seem to be attacking certain members of the community' (L1082-1083), 'on television there seems to be a lot of programmes attacking people who are either unemployed or overweight' (L1092-1093)* '*they could do more to stop the negative stuff I think you know [...] I definitely needed some help when I got here'* (L1097),*'People to be made aware of what's there, what help you can get you know. There's a lot of people struggling you know* (L1590-1591),' *I think if more people are made aware of it and what's available, the better, it's only gonna be beneficial isn't it?' (Bob L1595-1597)*

Bob's perspective highlighted the stigma associated with being Obese. He felt that social media, for example, comments on twitter were attributing a lot of blame to the individual and portrayed being overweight negatively. He suggested that more should be done in providing support to changing individuals' lifestyles. In support of this, research has demonstrated that attributing overweight and obesity to factors under individual control is associated with blaming and stigmatising attitudes toward individuals with obesity (Puhl and Brownell, 2003; Teachman, Gapinski, Brownell, Rawlins and Jeyaram, 2003), which in turn influences health. The internalisation of weight-biased attitudes among overweight individuals was associated with poor global health functioning above and beyond the effects of body mass (Latner, Durso, and Mond, 2013; Pearl, White and Grilo, 2014).

3.4.3. Role of Counselling Psychologist

3.4.3.1. Professionals

This part is concerned with the practitioners' understanding of psychology and the role it has in weight management programmes.

Dave identified outcomes utilised by psychologists, as well as them supporting patients with emotional eating:

> *'I am aware of […] you know self-esteem, HADS anxiety and depression and all those sorts of things and obviously seeing the patients I can sort've see the different types of problems that they would have so […] you know using food as a comfort 'n' different things' (L338-341)'certainly looking at that sort've motivation aspect. So I think that's a big thing and obviously seeing if there*

are any more deep rooted things that might obviously impact on a person's self-esteem or weight' (Dave L346-348).

Counselling Psychologists were identified as being able to explore deep rooted issues that may have impacted upon an individuals' weight as well as their self-esteem. This supported the idea of the role managing complex cases.

Amy attempted to distinguish between the type of psychologists and the work they would do:

'I guess you can have a clinical, counselling or health psychologists all working in that area' (L427-428), 'weight management and behaviour change would fall into health psychology a lot more than any other area of psychology, but then a counselling psychologist would be able to deal with the clinical issues better than a health psychologist but the health psychologist would do more of the actual weight management issues rather than the healthy eating change. Depression or self-esteem […] they would struggle with (L429-435), 'I'm not sure about the exact training a counselling psychologist gets to be honest other than the counselling side of it and the clinical side of it' (L450-453),'If I got to spend more time with people and if I actually did proper psychological therapy with people, then in terms of supervision role, I think if there are any clinical issues […] a general supervision role' (Amy L469-472)

Amy was able to identify a role of clinical supervision that could be delivered if she was seeing a lot of clients regularly. This is something that other professionals didn't

feel they could be supported by a psychologist. This highlighted the lack of understanding regarding the skills and competencies of a psychologist. Professionals' understanding did not extend further than psychological support being offered to patients. This could be due to the reduced input received from a psychologist within a programme. This will be discussed further in section 4.1.3.

3.4.3.2. Patients

Bob discussed that if information on the psychological aspect of the service was given as much importance as other aspects then this would raise awareness and maybe the uptake of the service too:

> *'with weight issues is, "Listen, you're not just going to be doing a diet, you know, they'll be psychologists to help you and support you as well if you're struggling you know and getting depressed with it all, being negative and what have you". I think if a lot of people knew that was there to help them' (L1418-1421), 'a lot more people would do it' (L1425),'and succeed with it, I, you know, I stand by that for sure'.* (Bob L1429)

Bobs comments suggested the promotion of psychology within weight management services would increase not only its uptake with psychology but the programme in general too.

Gill, Barbara and Bob discussed their understanding of what a counselling psychologists' role may entail:

> *'counselling psychologist. Do they exist? (Laughs) (L383),'I assume a counselling psychologist is somebody who is trained in counselling and*

trained in psychology. So they would presumably be twice as good!! (Laughs). Well not quite twice as good, but they would have a more, bigger range of skills in their kitbag to get you to where you wanted to be, I guess' (Gill L385-388).

'basically what you're doing now I should imagine […] to a degree […] you learn off people like me, which helps you in your research and helps you to go forward with other people that may have' (Barbara L713-715)

'counselling you with whatever you need, you know. Supporting you, showing you how to help yourself, and I should imagine things like that you know. How you can work to help yourself and make yourself better, changing the way you think and what have you' (Bob L1265-1268)

Gill, Barbara and Bob highlighted different aspects of a counselling psychologists' role. Gill felt they would be trained in counselling and psychology therefore extra skills to offer in supporting patients. Barbara focused more on the research aspect and Bob understood the role as the clinical element of supporting patients and bettering themselves. This is impressive for Barbara as she did not access psychological support at all. Overall there is a reasonable level of understanding from patients'. This puts the awareness of psychological support and raising the profile of a counselling psychologist in a positive light. Even though there can be varying types of support offered, as Amy was restricted to offering 20 minute assessments followed by group work, but other patients may have experienced 50 minute individual sessions too. For patients whose only knowledge and

understanding of psychological support is that of what Amy has offered, this could create bias in their opinion of the usefulness and or effectiveness of psychological interventions overall.

The Division of Counselling Psychology's Professional Practice Guidelines (2005), stated that counselling psychology developed models of practice and research which combine the scientific demand for rigorous empirical enquiry with a firm value base grounded in the counselling or psychotherapeutic relationship. These models included: engaging with subjectivity and intersubjectivity values and beliefs; to know empathically and to respect first person accounts as valid in their own terms; to be practice led, with a research base grounded in professional practice values; and to recognise social contexts and discrimination aswell as to work in ways that empower rather than control, as well as demonstrate the high standards of anti-discriminatory practice accordingly with contemporary society.

Further to this Woolfe, Strawbridge, Douglas and Dryden (2010), discussed that counselling psychology emphasises the subjective experience of clients and clinicians engaging with them as collaborators, seeking to understand their inner worlds and constructions of reality. The notion of 'being with them' as opposed to 'doing something' is promoted with the core conditions of empathy, acceptance and authenticity, which are emphasised irrespective of the therapeutic modality. Woolfe (1990) identified and highlighted some of the factors that counselling psychology prioritises as well as the therapeutic focus: the increasing awareness of the significance of the therapeutic relationship; the growing questioning of the 'medical model' of professional-client relationships and moving towards humanistic values;

and increasingly facilitating well-being as opposed to responding to sickness and or pathology.

Duffy (1990) stated that the difference between counselling psychology to the medical model and other psychological approaches is not the methods employed or the type of problem worked with, but the philosophical position that is taken. Therefore, the emphasis lies with 'being in relation' to clients rather than 'doing' to them. It is not a specific range of skills or the client groups that distinguishes counselling psychology, but more the approach and attitude or intentionality brought to the therapeutic relationship. This involves understanding a shared exploration into which the therapist brings their personal background. This is why the importance of personal therapy as well as supervision is emphasised during training and beyond.

This reinforced that a counselling psychologist can support patients who are struggling with managing their weight better by utilising different therapies as well as focusing on the therapeutic relationship. Newson and Flint (2011), discussed how individual or group-based psychological interventions should be included in weight management programmes and that psychological interventions should be individually tailored. As cited by SIGN (2010) guidelines, the range of psychological interventions included: self-monitoring of behaviour and progress; stimulus control; cognitive restructuring; goal setting; problem solving; assertiveness training; slowing the rate of eating; reinforcement of changes; relapse prevention; and strategies for dealing with weight gain. The behaviour chain analysis and identifying and addressing ambivalence may also be useful. Further to this, CBT (Molinari, Baruffi, Croci, Marchi and Petroni, 2005); CBT-E (Fairburn, Cooper and Shafran, 2003) and

Mindfulness based interventions (O'Reilly, Cook, Spruijt-Metz and Black, 2014) have all shown to be effective within weight management too (as discussed in section 1.5.3).

3.4.4. Limitations

This referred to where services can be quite limiting, whether this is financial or whether it is defining patient success.

3.4.4.1. Professionals

All professionals expressed that when providing an accurate picture of patient success with weight loss, using statistics such as percentage weight loss, in absence of other information, such as improvements to QoL can be quite limiting in determining overall improvement. It has been known for some patients that they have to repeat the programme more than once before a distinctive improvement is noticed, especially reflecting the set target scores.

Diane discussed how 5-10% excess weight loss is an agreed target and that meeting this is viewed to indicate successful weight loss:

> *'so anything that is between 5 and 10% is deemed as successful. I think a separate issue is how people feel so a lot of people may not achieve that 5 to 10%, but in themselves they feel much better' (Diane L79-81).*

What is not acknowledged is that the patient may not reach the agreed percentage but due to making some lifestyle changes could feel better, and that within itself is a huge contributory lifestyle factor impacting on an individual's QoL and supporting

continued weight loss. This then raised questions around what constitutes successful weight loss and where the 5-10% target originated from. It is important to identify these other factors involved in defining success for individuals.

Jim was also reluctant to defining success by the agreed percentages and was aware it was not the best measure of weight loss*:*

> *'I'm very loathe to define success by a percentage change in the scales because that's not an appropriate measure. And again, improvement in objective health measures is probably the best we have, but that doesn't cover the whole picture' (Jim L282-285)*

It was probably better to have acknowledged that the defined percentage figure is one way of measuring weight loss. This is a result of Rossner's (1991) interpreted outcomes of treatment by percent weight loss. He concluded that < 5% weight loss may reduce risk but was unsatisfactory, whereas a weight loss of 5-10% was considered a fair response. Goldstein (1992) recommended that 10% weight loss or less was needed to define clinical weight loss. Further to this Blackburn (1995), suggested that 5% might be one valid single criterion to assess significant weight loss. This was supported by two diabetes prevention studies, which illustrated the validity of the predefined percentage for weight loss, but did not necessarily indicate that this was the only way to measure success in weight loss, for example, waist circumference could be another way too.

This was further supported by Diane who discussed how measuring girth was not part of assessing successful weight loss, but she felt it was an important factor in determining weight loss:

> *'we don't measure girth and we have had a number of discussions about that because we don't report on it although we measure it (L83-84), 'we don't report on it, but we know if they have done well from the girth measurements' (Diane L90-91).*

The idea of using waist circumference to measure weight loss is supported by Lean, Han and Morrison (1995), who conducted a study in north Glasgow testing the hypothesis that a single measurement of waist circumference might be used to identify people at health risk both from being overweight and from having a central fat distribution. They found that waist circumference could be used in health promotion to identify individuals who should be offered weight management. Men with waist circumference 94 cm and women with waist circumference > 80 cm should gain no further weight; men with waist circumference >102 cm and women with waist circumference > 88 cm should reduce their weight. Findings of this study suggested that professionals may experience frustrations in being limited in the way weight loss success is measured. Professionals maybe empathising with patients experiences as well as their own understanding of how difficult patients may find losing weight. It could also be that professionals training and experience may lead them to have their own agenda and outcomes for interventions that sit outside of the medically prescribed goals.

Jim discussed the difficulty of measuring improvements in QoL, as it can be a subjective measure:

> *'so those issues in terms of quality of life are very poorly defined, and are day to day poorly collected, because there's no standardisation to it […] It's very difficult to say if your quality of life has improved, if your family circumstances have improved, if your relationships with loved ones have improved, if your employment chances have improved. That data is difficult to collect and is often not available' (Jim L265-270).*

Jim's perspective was interesting in that he felt the data had to be quantifiable, as opposed to qualitative data by asking the patient. To some extent this illustrated the institutionalisation in these practitioners, in that the NHS wanted measurable outcomes, even when, in cases like this, even when the outcomes cannot realistically be operationalised and measured in that way. Therefore on the one hand professionals find the system limited, but on the other hand they are thinking in this way!

3.4.4.2. Patients

Gill discussed how she could have benefitted from accessing a weight management programme a lot sooner than seven years. Initially since she did not fit the BMI criteria and therefore she felt she had to increase her weight to qualify for such a service:

> *'I've been ill 17 years and I knew I needed to lose weight and I desperately wanted to see a dietician for years […] but they wouldn't see me because my BMI wasn't over 30' (Gill L107-109).*

This highlighted the lack of resources available regarding weight management support, to the extent that an individual with physical health difficulties had to wait a number of years and in the interim her weight increased which may have resulted in further health difficulties before she was able to access such services*:*

> *'I had to wait until I got fatter […] to actually get the help which is absolutely ridiculous and there's loads of people in my ME group that desperately want to see a dietician and they can't because they're not quite fat enough, so you actually have to put on weight […] which is ridiculous […] you need the help when you need it. You don't need it sort of years later. So I would have preferred it […] 7 years ago' (Gill L111-117).*

It seemed apparent that QoL was not an indicator used to identify when patients required weight management interventions, only when actual weight loss was deemed necessary. This was in line with the practitioner comments on success, where services that were governed by numerical representation of patient experience, were not only proving difficult for patients but practitioners too. Measurements in QoL were neither looked at in detail at the point of referral nor end of treatment. Gills frustrations seemed apparent based on the length of time she had to wait as well as the protocol to be followed:

> *'you've got to get through the gatekeepers first' (L122-123),'7 years to qualify […] you need it when you need it really' (Gill L130-131).*

Ella experienced feeling limited as a result of not feeling supported by her family, as well as feeling judged by doctors, when attending for health issues as she felt she

was being told to just lose weight. It seemed that this did not help her levels of motivation to lose weight:

> *'Yes. I don't get praised in my house either. Nobody praises me. Mind you I don't think I've lost enough to, they haven't probably noticed yet' (L422-423). 'Everybody I go to see like doctors, about different things, whether it's like ear ache, or toe ache […], "Well if you lost weight blah blah blah" […],"Well yeah obviously" but I don't need people to keep telling me every five minutes […] that's why I'm doing this!' (*Ella *L373-377).*

Ella discussed how she did not get praised, which implied that she may need approval from others. In which case this raised questions as to whether her goals regarding weight loss and even life in general were for her or others.

Overall the findings for this theme suggested the frustrations and limitations of the predefined measurement of weight loss success, the difficulties patients can encounter in qualifying for weight management criteria, the stigma that can be experienced by patients as a result of social media but yet were expected to remain motivated to lose weight. There was a broader view apparent from patients regarding the role of a counselling psychologist than professionals.

3.5. Main theme five: Professional and personal beliefs and values

In this theme professional and patient beliefs and experiences were shared in relation to their views on obesity and weight management programmes, which in essence was part of the main aim to this research.

Sub themes- *Professional perspective, and Patient perspective.*

3.5.1. Professionals

The two main areas identified was their characteristics of successful patients which included: motivation; determination; open minded; some came with set ideas as to what such a programme entails from a healthy eating point of view; willing to be able to plan; willingness to make lifestyle changes. Diane discussed 'successful weight loss' in terms of excess weight lost,' *between 5 and 10% is deemed as successful' (L80).* She felt there was a difference between personal view and what they were given to work with:

> *'a lot of people may not achieve that 5 to 10%, but in themselves they feel much better' (L80-81) 'have lost quite a lot in girth but may not have lost as much from the weight point of view. Now we don't measure girth and we have had a number of discussions about that because we don't report on it although we measure it, because they didn't want to know about that' (Diane L82-85).*

Here there maybe tensions and frustrations present between what is expected of health professionals and realistically how this is adapted with patients. It may also feel limiting for professionals as they would want to praise patients, but having a limited 'vocabulary' to do this could make it difficult as success was being pre-defined by 5-10% weight loss as discussed earlier in Section 3.4.4. This highlighted the type of issues and conflicts that can occur between guidelines, policies and reality.

Dave and Kate defined success rather medically*:*

> *'some of them are achieving 20 – 30% body weight, weight loss, improvements in the other indicators blood pressure, cholesterol, umm blood sugar' (L114-116) […] 'those are the ones that have committed to the exercise' […] 'so they've attended regularly for their […] weight management consultations and also [...] use the gym frequently (Dave L118-1120),* as does Kate, '*start weight, finish weight, targets but if they hit the targets' (Kate L225).*

This is probably quite reflective of what is expected of him and the team as part of the programme.

Overall, professionals identified barriers of unsuccessful patients, which included: time; cost; life; stress; work stress; physical health problems; lack of exercise; pain; family and friends; and unsupportive partners.

Amy identified general barriers to be:

> *'Life, stress, work stress, physical health problems or any other illnesses, pain, or lack of exercise, because they can't, because of the pain, family members, friends, partners that aren't supportive, who eat a lot around them, not having a lot of time, or just something going wrong in their lives. And then everything gets messed up' (Amy L309-313).*

Amy then identified ways of overcoming psychological barriers as:

> *'how else they can be coping so it's just establishing good coping mechanisms really. And then I guess physical health-wise, a bit more difficult, they can always, if there is pain for example, weigh up what they can be doing and dealing with the pain' (Amy L326-329).*

This reflected the diversity of issues that can arise which are outside of the reach of the services.

Jim discussed barriers:

> '*they themselves feel a failure […] therefore lose engagement with the thing that was working relatively well' (L421-422) […]* '*they feel that this has failed, they give up the things that are losing the weight altogether'* (L423-424) […] *'demoralisation is one, sense of failure, and of course if they are demoralised and feel a sense of failure, they often disengage with the service' (L426-427) 'a barrier is kind of a self-inflicted barrier but it's very understandable' (Jim L431-432)*.

Jim may feel some of these barriers are a result of an individuals' own self. He then suggested overcoming these barriers by:

> *'it's part of our job to work with them to maximise success in every possible way we can, so there's no failures, there's no telling off, no admonishment, there's just trying to work through problems' (Jim L437-439).*

His suggestion was of addressing the negatives as part of his job and supporting and motivating the patients as best as possible.

Diane discussed one of the main barriers to be: '*they have to overcome […] is probably exercising, in front of people, because, I think, people are very self-conscious of how they look'* (*L166-168*). The venue of this programme was quite fortunate in that they have their own gym. So they give patients the nicety of being able to access a NHS gym, where others in a similar situation may not be attending one, in view of potentially increasing their self-esteem and confidence as well as their fitness levels.

3.5.2. Patients

This was similar to the professionals' experiences, in that the two main areas identified were also; characteristics of successful clients: determination; motivation; a goal; strong willed.

Both Gill and Ella discussed what weight loss success means for them:

> '*for me, it's been a success because I'm keeping the same so' (L158-159), and 'and not putting on more' (Gill L164).* For Gill it is about remaining the same whereas for Ella it is regarding what helps her to move forward. She says, '*after so many years I've actually done something about it' (L480-481),* so a sense of achievement. She also goes onto say, *'I'm waiting for […] people to notice more and say "You look really good, you look much better". Sort of waiting for praise that'll make me […] go a bit further' (Ella L490-491).*

Barriers to unsuccessful weight loss included: unable to exercise; lack of energy; lack of will power; hard work of preparing healthy meals; those who don't lose weight for health problems may give up after a short while; lack of motivation; lack of focus; lack of support; surrounding people can be unhelpful and negative.

Barbara defined barriers to weight loss as:

> '*I think if they've got children it can be difficult because they've [...] I know when I was younger, when my daughter was younger, I used to have a tendency to pick off, if she left something, left a chip on her plate, I'd eat it' (L436-438). 'People have got to be even more strong willed in that way' (Barbara L446)* if they are to overcome this barrier.

Further to this Barbara also said*, 'I came up to a brick wall, I couldn't, I wasn't losing any weight. People give up, could give up, at that point (L468-469).* Here she was expressing how she had struggled with barriers as such. She defined a barrier as, *'"oh I can't be bothered" or "I want that and I'm gonna have that", you know' (L503-504).* **'***It could be a lack of motivation, it could be will power that's not as good as it could be' (L508-509).* Motivation and will power seemed important to Barbara in overcoming obstacles and barriers. This was important to Ella too.

Bob's perspective on this was rather different to that of Barbara's and Ella's:

> *'after a period of time like you can get fed up as well and you think you know, I wish I could go back to the way things used to be. You know you start thinking*

> *differently as well' (L770-772).* '*You know especially when you're dieting and you feel hungry and you think "Oh God why am I suffering this", you know, that's what happens with me' (Bob L776-778).*

With Bob it almost seemed there was some hope of things going back to how they use to be. Still living in his past and wishing for that way of life to return but also realising the importance of moving on and adapting.

Bob's initial response to managing barriers was less positive:

> '*You can't manage some of them to be honest' (L903). 'If you was a bit more positive about it, and, thought about it, and worked it through in your mind, you could be, get through some of the barriers in your mind if you really wanted to' (Bob L931-933).*

Bob indicated that barriers can be managed but thinking through the problem is important.

There were two patients who had accessed psychological support and two who had not. Their overall experiences of accessing weight management services did not lead to any distinctive findings. But what was more apparent was the two that did not want psychological support, one being Barbara expressed that she had plenty of social support and or was quite confident within herself and that she can do this, *'between the help I've got here (L759-760),' with the guidance of what to do, and my own determination to do it' (L764) 'I find I didn't need anything else' (L768).* Whereas

with Ella there seemed to be a barrier present in that she did not need it and it could not do anything for her, *'I'm fairly, fairly, quiet and shy person anyway so I wouldn't have gone for that' (L153), I try not to let me emotions or anything out to […] other people (L209), 'I'm a private person but many people would need it' (L1104-1105).*

Whereas, with the other two patients they were open to trying psychology in aid of receiving all help possible to manage their weight better. One patient had accessed psychology in a different service in the past and this was something he was keen on receiving in his weight management programme too.

Overall differences between professional and patient perspectives on the role of counselling psychology were variable. It was fair to acknowledge that patients did not fully understand the role of a psychologist, especially a counselling psychologist. Although professionals did have a better understanding than patients, they still lacked an understanding of the role and therefore would struggle to explain the role to patients. For example, it was apparent when there was reluctance in receiving clinical supervision from a counselling psychologist, as they did not see how they could be supported.

The patients identified characteristics that did not seem too different to the professionals' views on both these areas too. They were also quite similar to research already conducted in this area. For example, Bestermann (2010) stated that there are a number of potential issues affecting an individuals' weight, ranging from family and socioeconomic factors to access to and relationships with healthcare

practitioners. Alm, Soroudi, Wylie-Rosett, Isasi, Suchday and Reider et al, (2008), furthered this by identifying specific barriers to weight loss including: low motivation; negative peer pressure; a chaotic or unstructured lifestyle; a negative body image; and unrealistic goals. A desire to be socially accepted and to prevent future obesity-related medical conditions are usually motivating factors for losing weight.

Alm et al (2008) also suggested that a good support system is helpful to promote the behaviour changes that are usually necessary for weight loss. This literature indicated the importance of being aware of the barriers and promoting the positive characteristics to help support and maintain weight loss. This is quite pertinent for the current study as it helped in identify areas where psychology maybe able to play a greater role.

3.6. Interlinks between themes

The findings indicated that there are interlinks between all themes with 'tension' sitting as the central theme, the underpinning frustrations and tensions amongst professionals and patients with factors impacting and surrounding weight loss. These were reflected in the main themes of: QoL; Lifestyle; Service Delivery Models; and Professional and personal beliefs and values, as well as the sub-themes leading into these main themes. This is discussed below as to how the themes linked.

The main theme of QoL has frustrations and 'tensions' present between the sub-themes of 'actual' and 'ideal'. For example, a patient may have significant health difficulties, which is a hindrance to their weight loss progress. These frustrations can

be apparent in the patient too, where ideally they would like to do a lot more than what they actually can. For example, being able to exercise more, afford and or cook healthy meals. From a professional perspective when the advice offered, for example, exercise and or healthy eating is not being followed accordingly this can create underlying tensions that professionals may view guidance not being taken seriously, impacting on their overall success of weight loss. The sub-themes reflected here included; 'physical health', 'psychological well-being', 'dietary' and 'physical activity', leading into the main theme of 'lifestyle'.

For a professional the QoL theme and its tensions could be apparent when trying to manage the requirements of the programme between governmental guidelines and targets set, so the 'government' sub-theme and practically offering a weight management programme, the 'structure' sub-theme with obstacles and difficulties that may arise from this have not been accounted for in the guidelines. For example, requiring increased psychological sessions to support patients as well as staff, but this may not be factored into the structure of the programme well. This could be in the sub-theme of 'role of psychology' all leading to the main theme of 'service delivery model'. From a patient perspective the frustrations and tensions of the structure of the programme can mean to make regular visits to see different professionals, this could have financial implications for them too. It could also mean from a governmental guideline perspective what may be expected of them is hard to achieve, i.e. exercising a considerable amount to be able to lose weight whilst struggling with specific comorbidities.

The main theme of ‘professional and personal beliefs and values’ can also have tensions apparent, for example, when professionals may make comparisons and potentially lead into judgements of those patients who can make good progress irrespective of health difficulties versus those who struggle as a result of their health. Some patients may feel these judgments are reflected in their weight loss progress. Conversely, patients’ health may genuinely be hindering their weight loss progress and previous experiences may distort their beliefs about receiving the right support. Any beliefs they have about the programme and if they can complete it may bring a set of frustrations and tensions within itself. There may also be tensions apparent between professionals and agreeing on the best care plan for a patient to maximise the benefits they may gain from attending a weight management programme. This would also be dependent on the patients; QoL as well as their lifestyle. This would also be impacted by the service model they receive as well.

The following section provides a summary of a discussion for the findings of this research accompanied by considerations of clinical implications, limitations, and future research.

Chapter 4-Discussion Summary

4.1. Findings

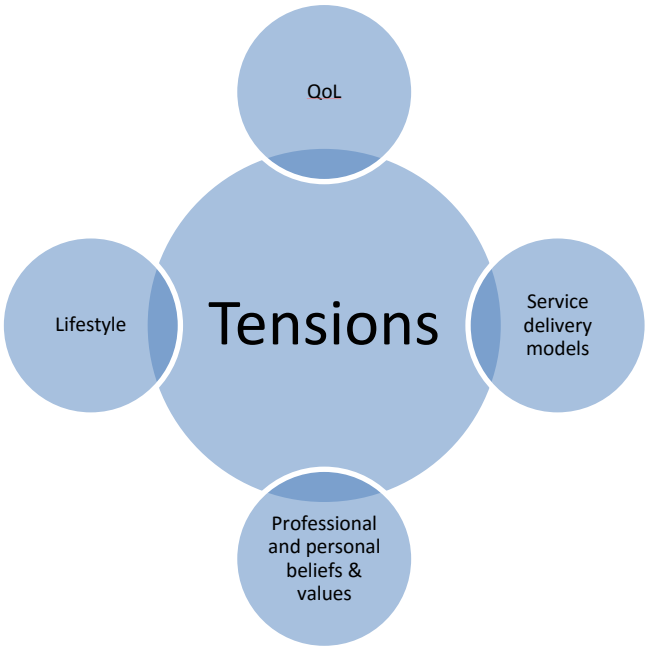


Figure 4.1. [Tensions in weight management interventions.]

The main findings were based on the themes in the model above (also see Appendix 10). The findings have addressed the objectives of this research which looked at: exploring patient experiences of attending a weight management programme; both professional and patient views on the importance of psychological support with weight management programmes; to elicit health practitioners and patients' views of the barriers to access and limitations of the current support offered; to identify health practitioners and patients views about the current and potential contribution made by national policy, guidelines and standard clinical practice.

Tensions' was the central and pivotal theme in this study which was present for professionals and patients. For professionals it was more to do with the patients' reluctance of accessing services, for example, psychology. Professionals' frustrations of being held back by service frameworks to be able to provide more for patients combined by a patients' potentially low motivation could evoke tensions. For patients, tensions were predominantly surrounding the ease of accessing services and having to wait until they met the criteria which resulted in an impact on their physical and emotional wellbeing. This was discussed in the findings with regards to the literature review by Blount (2003) on collaborative care, which highlighted the effectiveness in care if the relationship between mental health and medical providers, the population served and the type of service provided were adequately specified. Ultimately, working collaboratively across all involved is of the essence, which would in theory alleviate building tensions.

4.1.1. Quality of Life

There was a gap identified between the 'ideal' and 'actual'. One of the main contributory reasons for this gap was the restriction of activity as a result of physical as well as mental health. This was a tension amongst both professionals and patients. From a professional perspective poor compliance and non-adherence to treatment would be an easier way of understanding when weight loss success was not achieved. (This has been discussed in section 3.3.2. with Miller, Hill, Kottke and Ockene, 1997). Another approach to tackling adherence would be by utilising psychological support in using conceptual theories and health behaviour change models including: Stages of Change Model (Prochaska and DiClemente ,1983); the

Health Belief Model (Becker,1974); Social Cognitive Theory (Bandura and Schunk, 1981; Bandura,1997); the Relapse Prevention Model (Marlatt and Gordon, 1980; 1985); and Social-Ecological Models (Grzywacz and Fuqua, 2000; McLeroy, Bibeau, Steckler and Glanz,1988).

Magallaresa and Schomerus (2014) stated that although BMI represents an important medical indicator of health, it does not adequately demonstrate the patients' functional impairment in their daily life. They conducted a meta-analysis that compared mental and physical health related QoL measured with the Short-Form 36 of obese patients' pre and post bariatric surgery with a follow-up measure, up to a year later. Results found that obese patients reported a higher level of mental health quality of life after bariatric surgery, as well as physical health. It was found that HRQoL improved dramatically after a short-term follow-up (one year or less) among patients undergoing bariatric surgery. Overall, the results indicated a strong improvement in obese patients' experiences, both mental and physical components, after receiving bariatric surgery.

Magallaresa and Schomerus (2014) identified that not all patients in the studies used in this meta-analysis experienced the same improvement in their quality life. Therefore future studies should explore the variables involved further to understanding these differences. This literature emphasised the importance of QoL and HRQoL in weight management. This research supported this study in that health related illnesses can have a significant impact upon an individuals' QoL as well as the progress they can achieve with weight loss, for example, patient Gill. This

reflected the current findings of this study despite the patients of the present study not undergoing bariatric surgery, but that they felt better for being involved in making healthier lifestyle changes and managing their weight better, which consequently had a positive impact upon their physical and mental health, for example, patient Barbara.

Magallaresa and Schomerus (2014) findings could give rise to the question of whether obese individuals should consider bariatric surgery without exploring all other options first. Although NICE guidance does stipulate that patients are not eligible for bariatric surgery without exploring all other options first. This may be partly due to the huge costs attached to surgery and hence implications on health care finances if cases for surgery increased dramatically. However, a systematic review and economic evaluation conducted on clinical effectiveness and cost-effectiveness of bariatric surgery for obesity found that it appeared to be a clinically effective and cost-effective intervention for moderately to severely obese people compared with non-surgical interventions. Although further research needs to look for resolution and or development of comorbidities such as Type 2 diabetes and hypertension, so that the potential benefits of early intervention can be assessed (Picot, Jones, Colquitt, Gospodarevskaya, Loveman, Baxter and Clegg, 2009).

Whether undergoing surgery improves QoL was discussed in Section 1.5.1., where Ballantyne (2003) discussed that quality of life was multi-faceted. They too questioned the relative importance given to physical weight loss, evident by the scales, versus all other factors contributing to an individuals' well-being. This raised

a huge importance for the role of psychology in weight management services, which contributed positively to the emotional well-being of an obese individual. For example, using CBT (Safron et al, 2011; Fairburn, Cooper and Shafran, 2003; Molinari et al, 2005), Mindfulness (O'Reilly et al, 2014) and to enhance these psychological therapies / techniques EMI could be utilised too (Heron and Smyth, 2010) as mentioned in section 1.5.3. This highlighted the role for psychologists in such services, especially when consistent associations have been made between obesity and depression, low self-esteem, and poorer quality of life, especially in circumstances where the person is seeking help (Jones, Grilo, Masheb and White, 2010).

4.1.2. Lifestyle

Dietary and physical activity can be compromised and create tension when physical as well as emotional health has a negative impact upon an obese individuals lifestyle. This could then portray the individual to be lacking motivation, self-confidence and willingness to change. This could be supported by psychological interventions, for example, using CBT (Safron et al, 2011; Fairburn, Cooper and Shafran, 2003; Molinari et al, 2005), Mindfulness (O'Reilly et al, 2014) and to enhance these psychological therapies / techniques EMI could be utilised too (Heron and Smyth, 2010) as mentioned in section 1.5.3. Although the findings of this study showed the opposite, that the patients were good examples despite health issues they were still motivated and confident to continue making lifestyle changes in line with weight management programmes. For example, Alm et al, (2008), identified a desire to be socially accepted and to prevent future obesity-related medical

conditions as frequent motivating factors for losing weight (this has been discussed further in Section 3.5.2.).

Another finding highlighted the role of partners and family members in supporting their loved ones with their weight loss. It was questionable as to whether Bob's wife was a compulsive care giver and expressed her love and affection by feeding and nurturing her husband. Maybe it is worth partners being involved in therapy to help them to understand how such dynamics can hinder weight loss progress. This is reflected in obese children when their mothers' insecurity is expressed through the provision of food rather than emotional comfort (Trombint, Baldero, Bertaccini, Mattei, Montebarocci and Rossi, 2003). In much the same way that those who binge eat regulate their emotions with food (Nicholls, Devonport and Blake, 2016); these mothers may be regulating their childs' emotions with the use of food. This could translate in to the adult caregiving relationship too, by example of the partners of the participants in this study.

Trombint et al (2003) found that mothers who had an insistent requirement of idealising their own role as a parent and rewarded expectations that confirmed the efficacy of their care provided had predominantly obese children. They suggested that it may be important to include a psychological intervention addressing the relational dynamics between these mothers and their children. This idea of psychological support could also be provided to family members of patients attending weight management programmes where such relational difficulties may be present. This could be addressed by using systemic psychological interventions,

which were reviewed well by McLean, Griffin, Toney and Hardeman (2003); as well as CBT(Safron et al, 2011; Fairburn, Cooper and Shafran, 2003; Molinari et al, 2005), Mindfulness (O'Reilly et al, 2014) and to enhance these psychological therapies / techniques EMI could be utilised too (Heron and Smyth, 2010) as mentioned in section 1.5.3

The findings from the present study indicated that there was a lack of understanding apparent from both professionals and patients as to how psychological support could be applied, especially by a counselling psychologist specifically within such programmes. One example area mentioned where it could be applied was emotional eating. Despite discussing lifestyle and QoL there did not seem to be any links made between these and psychological support. There is plenty of literature that addresses emotions and overeating. For example, Mussell, Mitchell, de Zwaan, Crosby, Seim and Crow (1996), found important implications for the treatment of Binge Eating Disorder (BED). Due to the elevated rates of (subclinical) depressive symptomology and affective disorder among BED samples, therapeutic interventions designed to reduce depressive symptomology through psychotherapy or pharmacological interventions to provide advice in the treatment of BED would prove to be beneficial. Individuals may benefit from aspects of cognitive behavioural therapy that focus on affective triggers of binge eating and related cognitions more so than aspects to help dietary restraint.

Findings of this study identified how psychology could be used in weight management programmes, for example, addressing emotional eating, encouraging

motivation, self-esteem and confidence to attend and maintain attendance at such a weight loss programme. For example, using CBT (Safron et al, 2011; Fairburn, Cooper and Shafran, 2003; Molinari et al, 2005), Mindfulness (O'Reilly et al, 2014) and to enhance these psychological therapies / techniques EMI could be utilised too (Heron and Smyth, 2010) as mentioned in section 1.5.3. However, these applications were not suggested by the participants, rather they were inferred from the participants' views on current service provision.

The findings of this study understood that the professionals' perspective emphasised the gap for psychological input in NICE guidelines and how they are used as a minimalist resource in such programmes, an ad-hoc as opposed to an integral part of the team. This corresponded with results of this study, under the sub-theme: structure, which illustrated how patients felt more psychological input, was needed as well as professionals. For example, it seemed that Kate could have benefited from receiving training to promote her self confidence in addressing emotional eating. This finding had extreme significance for the present study and its aim of addressing the importance of psychology in weight management services from both a professional and patient perspective.

There was very minimal data that reflected the types of approaches that could be used within psychological sessions. Whereas, the literature suggested programmes where there is a role for counselling and psychological support, there is mention of different types of approaches that have aided weight loss. Kushner and Pendarvis (1999) found the patient centred counselling approach to be effective. Wadden et al

(2011) found behavioural modification counselling and Pollak et al, (2007) found MI to be effective.

Jeffery, Drewnowski, Epstein, Stunkard, Wilson and Wing (2002), stated that they recognised the need for further study into the behavioural and psychological differences between the processes of weight loss and maintenance, as well as the mechanisms through which physical activity and social support have their effects on weight maintenance. An example of ill health impacting on quality of life and an individuals' life style was a study by Oster, Harding, Dukes, Edelsberg and Cleary (2005) which found older adults who experienced longstanding, severe, and debilitating pain, resulted in poor health-related quality of life as well as high levels of dissatisfaction with treatment. This was discussed in section 3.2.2.2. Conversely, for the present studies results (see section 3.2.2.2.) patient Bob was trying to manage his pain levels partly by using exercise. Although he is younger than the population used in Oster el al (2005) study.

4.1.3. Service Delivery Model

The findings suggested there was frustrations and tensions apparent for professionals working with patients towards predefined weight loss success of 5-10% (Rossner, 1991), especially when they could see that they will not meet this target but it was apparent they were losing weight in others way i.e. waist circumference (please see Lean, Han and Morrison, 1995) as discussed in section

3.4.4.1. This raised the question of why waist circumference was not considered as part of the weight success criteria.

Another finding was the lack of understanding with the type and level of support a psychologist could provide to professionals who work in weight management services. A study conducted by Melin, Karlstrom, Berglund, Zamfir and Rossner (2005), explored whether there were differences in organisational settings and professional intervention between health professionals, who after one year of education, and on-going supervision for 30 months started obesity programmes and those who did not, and what factors facilitated the implementation and the start of such obesity treatment. Supervision consisted of education sessions and question and answer time, which showed to a have a significant positive influence on starting an obesity treatment programme.

The varying understanding of the psychological support received by patients could also be confusing for patients who have accessed counselling and psychology in different services. When interviewed Amy stated she was offering 20 minute assessment sessions followed by group sessions, whereas individual sessions was also a key part of providing emotional support. This could also be highlighted in the differences in the type and level of services, especially psychological support offered within weight management programmes offered locally and nationally. This is discussed further in section 4.1.4.

Melin et al (2005), study showed significant differences in the characteristics of health care professionals who started the obesity programmes to those who did not. They identified major obstacles to educate and train health care professionals; this included time and financial resources. This indicated the positive impact of education and supervision, more importantly supported by a psychologist, but professionals who have not utilised this may not understand its importance in professional development. For the present study this could be providing Kate with supervision and education to enhance her confidence in managing emotional eating in patients better. This is one potential role for a counselling psychologist within weight management services, as they are currently underutilised as trainers.

Further to this Connolly, Deaton, Dodd, Grimshaw, Hulme, Everittet al (2010), looked at a study which aimed to examine current discharge practice in one hospital and then compared perceptions of this activity between healthcare practitioners from different professions. To analyse the data they used descriptive and inferential statistics. They had 455 questionnaires that were returned from nurses, midwives, doctors and therapists and allied health professionals. Tensions between professional groups were evident, especially between social workers, nurses and doctors, but also between practitioners, patients and carers.

Connolly et al (2010) suggested that a better understanding of other roles and expertise of team members may improve this process. It was highlighted that the survey method had a number of limitations and conclusions should be considered with caution. This was evident with most of the professionals interviewed for this

study, in that they did not understand how a counselling psychologist could support them. Or it seemed to be interpreted in the context that they needed further support, which the researcher believed potentially led to some reluctance of them being forthcoming with this support. This also highlighted the gap for the lack of awareness in understanding psychology, which reinforced the lack of understanding of a counselling psychologists role in such services, as found by the present study.

It was also discussed in sections 1.5.2 and 1.5.3, regarding the effectiveness of psychology within weight management services (for example see, Minniti et al, 2007; Molinari et al, 2005) but from this study's findings the researcher realised that not only is there a reluctance in some patients in accessing psychology, but in staff too, highlighting the need for further education in understanding the role of a psychologist. It leads the researcher to consider whether there are significant power and inferiority issues around roles and responsibilities. Does this also raise hierarchical issues in where a psychologist, especially a counselling psychologist is best placed within such services. Once again there is an identifiable gap here on understanding the place of psychology and how best it can support staff and patients in weight management services. It is evident from section 1.5.3 that psychological interventions such as, CBT (Safron et al, 2011; Fairburn, Cooper and Shafran, 2003; Molinari et al, 2005), Mindfulness (O'Reilly et al, 2014) and to enhance these psychological therapies / techniques like EMI could be used as well (Heron and Smyth, 2010).

Robinson and Cottrell (2005) conducted a research project funded by the Economic and Social Research Council (ESRC), investigating the reality behind the rhetoric of 'joined up thinking'. It was a qualitative, multi-method study that consisted of: observations and documentary analysis; interviews; and focus groups around decision making and knowledge sharing. The study looked at perspectives of professionals in multi-agency teamwork on their professional knowledge and learning ways of working.

Findings of this study also suggested professionals' job role and satisfaction being compromised. Power and status factors are an implication of these findings. Actual and potential conflicts between professionals are explored about models of understanding, roles, identities, status and power, information sharing and links with other agencies. There was the concern of balance between specialist and generalist skills and status; there was a pressure of retaining a specialist role as well as fitting into the service needs. The dilemmas included: status; expertise; and the distribution of power regarding status clashes causing distress. Different professionals may set a different value on status differences and in multi-agency teams this could be a factor in creating tension between professionals.

Robinson and Cottrell (2005) found that the psychologist discounted status issues whereas the social worker was preoccupied with it. They concluded on some implications of findings in theory and practice for professionalism within integrated, multi-professional teams building new ways of working. This study is one example that highlighted tensions within professionals working within a multi-disciplinary

team, which is similar to the multi-disciplinary team set up of the professionals recruited for the current study.

This studys' findings suggested a patient perspective on the experiencing of weight related stigma. Personal responsibility attributions were associated with higher self-blame, fat phobia, and internalisation of weight bias. Given the negative mental and physical health consequences associated with external and self-directed weight stigmatisation that may impair weight loss efforts (Puhl and Heuer, 2010). The importance of 'personal responsibility' is often emphasised in arguments against the need for public policies to support obesity prevention and reduction efforts (Brownell, Kersh, Ludwig, Post, Puhl and Schwartz et al, 2010), attributing obesity to personal responsibility being associated with reduced support for government intervention amongst the public (Bleich and Blendon, 2011).

The Foresight report (2007) stated that people who are obese can experience stigmatisation and bullying that can lead to depression and low self-esteem. This highlighted the role of psychology and more a counselling psychologist in supporting patients and practitioners who are involved in weight management services. Psychological interventions such as CBT (Safron et al, 2011; Fairburn, Cooper and Shafran, 2003; Molinari et al, 2005),and or Mindfulness (O'Reilly et al, 2014) could be used to support such people in obesity services.

There is a knowledge gap, with negative attitudes towards obese patients and obesity management. Education in increasing awareness, increased sensitivity, and providing a detailed understanding of the current practice to determine how to best stop the epidemic of obesity is important (Fogelman, Vinker, Lachter, Biderman, Itzhak and Kitai, 2002). According to this study, negative attitudes identified, in working with this patient group, for example, lack of motivation can be reversed by education and interventions to modify negative beliefs about obesity (Phul and Brown, 2001; Feste and Andersson, 1995; Milne, Baker, Blackburn, James and Reichelt, 1999; O'Meara. Glenny, Wilson, Melville and Sheldon, 1997). Psychological interventions could be utilised as mentioned in section 1.5.3. The implications explored as a result of this study considered the 'permanent supervisor function' as a significant role for psychology in weight management services.

This highlighted the importance of taking responsibility, as within managing obesity taking responsibility for an individuals' health is important. It maybe arguable as to how much of this is taken on a personal level versus an organisational level.

4.1.4. Professional and Personal beliefs and values

The findings with regards to beliefs and values were quite similar for both professional and patient perspectives for characteristics of successful patients and barriers encountered. There were tensions present from both perspectives with the barriers encountered and the implications this has for these individuals. From both perspectives successful characteristics to weight loss included: motivation;

determination; open minded; some came with a set of ideas as to what such a programme entails from a healthy eating point of view; willing to be able to plan; willingness to make lifestyle changes; a goal and being strong willed.

The identified barriers included: time; cost; life; stress; work stress; physical health problems; lack of exercise; pain; family and friends; unsupportive partners; unable to exercise; lack of energy; lack of will power; hard work of preparing healthy meals; those who don't lose weight for health problems may give up after a short while; lack of motivation; lack of focus; lack of support; surrounded by people who can be unhelpful and negative. There are numerous areas mentioned in the barriers where psychological input could prove to be beneficial and reinforce the importance of psychology in weight management services using counselling and psychology. The World Health Organisation (WHO) acknowledged that healthy behaviours at the individual level are only possible within environmental frameworks that promote a healthy lifestyle (Obesity and Overweight Fact Sheet, 2013).

The present studys results supported Bestermann (2010) and Alm et al (2008) study's as discussed in section 3.5. This highlighted the barriers and consequently where psychology could play a greater role in promoting positive changes.

Overall findings of this study are reflective of other weight management services in the UK. For example, Jolly, Lewis, Beach, Denley, Adab, Deeks et al (2011), conducted a study assessing the effectiveness of a range of weight management

programmes in Birmingham, England, where eight Randomised Controlled Trials (of 740 obese male and females) were examined in a weight loss programme of 12 weeks: weight watchers; slimming world; Rosemary Conley; group based, dietetics led programme; general practice one to one nurse led counselling; pharmacy led one to one counselling. This study highlighted the variation and inequality in the emotional support offered within different weight management programmes in the country. A contributory factor to this maybe the broad NICE guidance provided, leaving such programmes to tailor their services in accordance with cost and local availability of psychological provisions. Jolly et al (2011) stated that although primary care practitioners were trained in weight management counselling, they had considerably less experience than counsellors / group leaders of other programmes, as this is one of a multitude of other roles they have to fulfil in primary care.

Jolly et al (2011), also found that as opposed to one to one the dynamics of a group may be an important part in supporting weight loss (Renjilian, Perri, Nezu, McKelvey, Shermer and Anton, 2001). There was feedback from participants who did not complete the full programme suggesting that they had difficulties in arranging convenient sessions so these often did not occur on a weekly basis for the primary care programmes. This could be implied as additional costs to attend appointments, which was reflective of one of the barriers in the current study. This was mentioned in section 3.5.1.

Finally, Jolly et al (2011) reported evidence to suggest that primary practitioners confidence was quite low in being able to deliver effective positive change in their

patients weight (Leverence, Williams, Sussman, Crabtree, and RIOS Net Clinicians (2007). A psychologist could provide support to increasing staff confidence in the form of supervision and teaching and training, as discussed in sections 3.3.4.1 and 3.4.3.1. Data from smoking cessation programmes show primary care services were less effective than dedicated cessation services (Aveyard, Johnson, Fillingham, Parsons and Murphy, 2008; McEwen, West and McRobbie, 2006). It was concluded that a 12 week group programme could clinically result in useful amounts of weight loss that were sustainable at one year in an unselected primary care population with obesity. The weight management programme explored in the current study ran for the course of 24 weeks with the first 12 weeks receiving weekly support. The frequency of this then reduced considerably in the remaining 12 weeks.

There were many limitations to Jolly et al's (2011) study, one of which included self-reported weight measurements where objective data was unobtainable. Further research could explore the most favourable amount of time for such programmes.

The limited long term support offered was also apparent in the current study and this had been reflected in the literature mentioned earlier in section 1.5.4. For example, Thomas et al (2008), as well as the lack of literature in this area (Gupta, 2014).

4.2. Clinical Implications

The findings indicated the need to raise awareness of psychological support in weight management services. The main difference found amongst patients who had

accessed psychological support as opposed to those who had not was that they had experienced counselling and therapy before. This encouraged them to seek this support again as they were aware of the positive impact upon them. This suggested that having therapy previously enhanced an individuals' trust that it will help, they have some idea of what it involved, and also they have already overcome any barriers to accessing psychological support. This is positive to learn as patients experiences of varied and differing psychological support within weight management services as well as otherwise could influence their understanding of how best psychological interventions could support them.

Ways of promoting psychological support could be: using posters and information leaflets distributed, for example, in GP surgeries; educating health professionals as well patients in the role of psychology and more importantly the varied role and skill set of a counselling psychologist and the valued contribution that can make to such services seems to be a significant identifiable gap. For example, a counselling psychologist could provide education and on-going supervision for professionals in weight bias and stigma. Consequently, this would have an impact on how psychological services are understood to the professional and who would be involved in promoting this to the patient. This could be extended to developing and delivering training to front line professionals to deliver basic screening and psychological interventions (for example, see Razavi and Delvaux, 1997).

The results of this study also suggested that an improvement is needed in social media and messages conveyed to the public regarding obese individuals. There is evidence from the literature and current health policy (for example, NICE public

health guidance 53, 2014) that obese people may be stigmatised. It was identified that professionals sometimes described their clients or patients as ' them', which tentatively could be an example of language that distances, promoting and sustaining a ' them and us' position that supports patriarchy in health systems. This is also supported by the TA social constructionist idea of language constructed within an environment**,** which gives rise for a discussion on the way language contributed to the social world as well as patient success.

This is supported by Pearl and Lebowitz (2014), where they found that advancing efforts to develop more effective public health messages and campaigns that promote health behaviours and obesity prevention policies without perpetuating weight stigma is important. In contrast, although obese persons have been stigmatised for decades, the prevalence of obesity has increased irrespective of discrimination present. This then raised the question as to what extent are obese individuals affected by how the media and society portray them.

A major touchstone of the health promotion movement has been to make healthful choices the easy choices (First International Conference on Health Promotion, 1986; Milio, 1976). Mercer et al (2003), acknowledged that changing behaviours on food intake and physical activity are essential to life, but they suggested a more collaborative approach was required. A participatory research would be an important step in ensuring such cooperation. For example, a study design similar to that of the present research in obtaining a patients' perspective is equally as important as the professionals.

On a wider level, Mercer, Green, Rosenthal, Husten, Khan and Dietz (2003), stated that smoking cessation counselling was consistently more successful than obesity counselling, because of the broad organisation of comprehensive tobacco control efforts that have supported smoking cessation and reinforced systematic and effective counselling to achieve this. If changes are to be sustained, programmes must have sufficient organisational support, funds, resources and educational material (Centers for Disease Control and Prevention, 1999; Carlson, Chute, Dacey et al, 2000; Bjornson, 2000). Overall, Fildes, Charlton, Rudisill, Littlejohns, Prevost and Gulliford (2015), emphasised obesity treatment programs should prioritise prevention of further weight gain along with the maintenance of weight loss, this supports Brownell (2010) point, as mentioned in section 1.7.

4.3. Limitations

Both an advantage and disadvantage to this study is the findings being from one organisation. It is known that the service being delivered is the same for all patients. Weight management services vary throughout the country, so having homogeneity in this study was useful. Another advantage to the study being conducted in the same organisation was that the recommendations can be made directly to that service, as it is specific to them. A disadvantage to this is it may be that the organisational and cultural influences have had a bearing on the interpretations made in the findings.

Other limitations included: this research being a small exploratory study that would need to be replicated in a larger population; there was a limitation of general application of participants who were seeking medical services and therefore that

would make the findings of this study unrepresentative of the general obese population who may not have accessed NHS weight management programmes; the researcher did not collect data about how many participants were approached therefore it is not possible to obtain a response rate and this potentially may have implications for the generalisability and transferability of the findings from this study; from a methodological perspective thematic analysis was used and one of the limitations found with this analysis was the steps taken to ensure pure TA was conducted, which was difficult as the guidance provided for the method of using TA was broad, leaving a lot open to interpretation.

Therefore, developing codes and themes is predominantly based on the interpretation of the researcher (s). It is likely that the researcher being present is inevitably going to create some researcher bias. Creating themes can be very subjective and therefore is predominantly an interpretation of the researchers understanding of the data collected with inferences held as a result of; contacting, meeting and interviewing participants and then undertaking the TA process. In order to ensure a variety of perspectives were taken into consideration the researcher discussed the codes and themes with a fellow colleague, as well as university tutors. These findings could have been shared with other objective bodies before finalising the results, but as this research is part of a professional doctorate timeframes were constrained.

Despite these limitations the quality of this research (as mentioned in section 2.6.1.), demonstrated credibility to the findings and any suggestions offered, were based on the findings of this study which are indicative of an on-going weight management

programme with professionals who have worked in it for many years and regular referrals of patients who have accessed it.

4.4. Future Research

There would be areas of research applicable in both quantitatively and qualitatively. Quantitatively there is scope to develop measures or use existing measures within this population, for example, quality of life measures and or appropriateness of psychology within such services. Qualitatively, similar studies could be conducted with non-NHS organisations, for example, slimming world, weight watchers or private facilitated weight loss programmes. Specific populations could be targeted, for example, BME communities, differences between male and females understanding of the place of psychological support within weight management services. A follow up from the present study could evaluate the use and effectiveness of recommendations applied, especially on service delivery and outcomes.

There is a significant gap identified with the role of a counselling psychologist within this research. This may be an area of further work on understanding how psychological services form part of an integral weight management MDT, to then specifically focus on the explicit role of a psychologist, especially a counselling psychologist within this. To improve the understanding of obesity as a chronic but manageable condition it is important to act on all levels: government; education providers and trainers; media; health professionals and patients (Kristeller and Hoerr, 1997; Melin, (as cited in Melin et al, 2005) and Kopelman, 2001). From the findings of this research it would prove to be beneficial to explore further professional

relationships and conflicts that maybe impacting upon their job and hence the quality of the weight management service provided.

There is a lack of literature, for example found by Gupta (2014), regarding the barriers and facilitators of long term weight loss amongst adults in the UK. Although this study did not focus explicitly on long term and maintenance factors of weight loss, it is evidently an area of potential for further research. Findings of such literature could shape weight management programmes to support effective long term weight loss and the role of a psychologist within this too.

Pearl and Lebowitz (2014) suggested that future work could test the effects of educational campaigns and media coverage focusing on environmental factors contributing to obesity, in comparison to existing campaigns focusing on personal responsibility or biology. Their findings give rise to how best to promote obesity prevention and intervention without stigmatising obese individuals.

4.5. Conclusion

The originality of this research was in exploring the role of counselling and psychological support in weight management programmes from both a professional and patient perspective. The uniqueness of this study was that it is a reflection of a particular organisations weight management service in a NHS trust. Therefore the recommendations can be considered specifically to that programme as well as generically by other services.

This exploratory study using the framework of thematic analysis has highlighted tension on many levels explored in all themes created. This study illustrated a lack of awareness and understanding in a counselling psychologists' role from both perspectives. This exploratory study has identified the need for further research into the content of counselling and psychological support and which aspects and approaches might promote behaviour changes, especially in weight management services as well as support to professionals through education, training and supervision.

From a professional perspective patient adherence and possible non-compliancy posing as a difficult barrier and tension, whereas with patients health related difficulties can impact upon motivation and readiness to change. There is an identifiable gap between what is manageable (actual) versus what an individual would like to do (ideal). This study also highlighted the stigma associated with obese individuals and the level of emphasis placed upon personal responsibility. With media messages being perceived by obese individuals as attacking and offensive, this clearly warrants a huge area of further work on improving media portrayal of obesity being vital. There are also tensions with professionals and the service framework of having to work to predefined weight loss success which is not always reflective of true weight loss success as well as tension and conflict within teams.

Ultimately, this studys' findings indicated that there is a greater place than at present for the role of psychology in weight management services, whether it is as a patient, a professional, health care provider and more importantly as a society to manage obesity better.

In the following section the researcher shared their reflections of the research process.

Chapter 5: Critical Appraisal

This critical appraisal reflected my journey on this professional doctorate and more the challenges I have encountered whilst undertaking my research as well as the learning opportunities I have embraced in developing as a scientist practitioner. I will discuss my interest in this research topic as well as share reflections from my research diary maintained throughout the course and research process.

5.1. Conducting the research

I found it easier to recruit professionals and a significant part of this was probably due to working in the same NHS trust. Whereas, recruiting patients was a lot more difficult, as there was a gatekeeper involved to ensure confidentiality for the patients. On occasions this created huge frustrations due to a delayed or slow response from the gatekeeper, which was adding pressure to my timescale of collecting participant data, to then transcribe and analyse. I learned that building a good relationship and effective communication skills were important to convey the message of the urgency to accessing participants needed, so that I could work towards my research deadline. This also involved meeting with the service manager and requesting that they co-operated with me. This all contributed to developing my skills as a scientist practitioner, as conducting research in a NHS setting where the service can be under-resourced with extensive demands meant communicating was a key aspect to receiving their support and completing this study.

Although there was a reasonable sample size for a qualitative study, ideally it would have been beneficial to have recruited additional participants**.** I would like to have recruited more patients who had and had not accessed psychological support to identify any further themes. Due to time constraints with completing the professional doctorate course this was not feasible, but there is scope for future research ideas in improving the validity, credibility and transferability of this research including; conducting a similar study to this one but with non-NHS organisations and or with BME communities. It is important to have an awareness of potential gaps in literature and possible areas to research, which adds value to the role of a scientist practitioner.

The fact that I had worked with some of the professionals I interviewed for my research, consequently made it easier to access them. But it also made it slightly awkward in being an objective researcher and going into the interview without any prior knowledge of them. In spite of this Miyazaki and Taylor (2008) recognised that a researcher being present to collect data inevitably creates researcher bias within a study.

With one of the participants I felt at times he did not understand my questions very well, which created self-doubt regarding the appropriateness of the interview schedule. But I also then questioned if other professionals and patients struggled to understand these questions too. In some of the interviews, especially with patients I felt at times I was taking on the role of a therapist whilst asking questions, as I felt I was probing more around their understanding of psychology within weight

management services. Although this was to obtain optimal rich data as possible, it also could have felt like a therapy session too, which is more likely to happen if a rapport has been built. I did feel I created a reasonable rapport with most participants.

Admittedly, it was easier to conduct the interviews with professionals who I was already aware of. At times, self-doubt was present as to whether I was following the procedure of conducting a research interview properly, hence reflecting on my lack of confidence in conducting them. Whilst conducting the third professionals' interview it started to become apparent that the participant had little understanding of counselling psychology as well as its role within weight management services. This then became apparent in the patient interviews too.

At this point I started to feel somewhat frustrated with realising this, as I was afraid this would result in less rich data. I was also quite surprised as to how little professionals did understand about the role of psychology within weight management services, let alone the role of a counselling psychologist within itself. I was not surprised at patient responses around their lack of understanding of a counselling psychologists' role, as I had experienced this in my work placements too. But I questioned whether I had high expectations from professionals as opposed to patients.

Retrospectively, I feel my frustrations were around the expectations that I had created, in assuming professionals would understand the role of psychology in weight management services well. Once it was apparent that this was not the overall feeling I was getting, there was some fear present as to the impact this would have on the richness of my data and hence the overall quality of my research. It could be argued that this is part of a research process and the uncertainty of what the data may reveal and overall contribute to an identifiable gap in the literature as part of becoming an experienced scientist practitioner. This is also the age old struggle for psychologists generally in demystifying their role.

Whilst analysing the data using thematic analysis, I was very aware of trying not to misinterpret the data and to be as methodical as possible with the iteration process. But to immerse myself in the data I think it was difficult to be totally objective to some extent. Even with identifying emerging themes I was mindful of trying to be as well informed as possible by the codes in the data before formalising sub-themes leading into the main themes. To try and maintain objectivity these themes were discussed with university supervisors and a fellow colleague on the professional doctorate course. This process had been a vital part in not only supporting my research but also in my on-going development as a scientist practitioner.

Another reflection was an improvement in my writing style. This was noted gradually over the course of completing the professional doctorate but also as a result of completing the research. This had been a result of; wider reading for my research and related topics, completing university workshop courses on writing styles and

referencing as well as reading a book on writing skills as suggested by one of my university supervisors. This has all contributed to developing my skills as a well-informed scientist practitioner.

Having spent a few years studying this topical area, I learned and understood the extent to which obesity had become a growing challenge in society. The NICE guidance recommended ways to manage this problem but there is still room for improvement. There is an identifiable role played by the patient, professional as well as the service provider.

I have agreed that after the completion of this research, a short report summarising the findings will be presented to the service, as well as a formal presentation to local GPs regarding the outcome of this research. This reinforces continued development in my role as a scientist practitioner. It has also been brought to my attention that in order to maintain a working scientist practitioner role, conducting on-going research is equally as important.

Conducting this research has been influential in many ways upon my clinical work as a practitioner. This included being more aware and explaining in simple terms what psychological support is, by seeking clarification from the patient as to how well they understand what I may have just explained. As well as when liaising with professionals regarding the level of psychological input agreed for such services, I have tried to be more clear of the identified need and data showing patient reported

therapeutic success. This can be a difficult task when NICE guidelines could be more specific with the level of input psychology could be offering such services. This has added to my on-going developing skills as a scientist-practitioner.

5.2. Conclusion

Overall, it has been an enjoyable but a challenging experience! The professional doctorate course as well the research has supported both my professional and personal development in numerous ways. This has included: furthering my knowledge and understanding of applying theory to practice; applying clinical practice to research and vice-versa; increasing personal awareness of not just in the therapy room but as an individual on a path of constant improvement, for example, learning suitable stress management skills and self-care methods adopted. This training course has supported in enhancing my confidence and resources of well-being, in developing internal meanings, to aid development as an efficient counselling psychologist in the work place as well as a scientist practitioner. This is presented and summarised well in the quote below by Moustaka (1990):

"I may be entranced by visions, images and dreams that connect me to my question. I may come in touch with new regions of myself, and discover revealing connections with others….If I am investigating delight, then delight hovers nearby and follows me around….Delight becomes a lingering presence….It opens me to the world in a joyous way and takes me into richness, playfulness and childlikeness that move me freely and effortlessly. I am ready to see, feel, touch, or hear whatever opens me to a fuller knowledge and understanding of the experience of delight" (p11.)

References

Alm, M., Soroudi, N., Wylie-Rosett, J., Isasi, C. R., Suchday, S., Reider, J. & Khan, U. (2008). A qualitative assessment of barriers and facilitators to achieving behaviour goals among obese inner-city adolescents in a weight management program [Electronic version]. *Diabetes Education, 34*, 277-284.

Ajzen, I. (1991). The theory of planned behaviour [Electronic version]. *Organisational Behaviour and Human Decision Processes, 50*, 179–211.

Ajzen, I. (2001). Nature and operation of attitudes [Electronic version]. *Annual Review of Psychology, 52*, 27–58.

Allison, D. B., Basile, V. C. & Yuker, H. E. (1991). The measurement of attitudes toward and beliefs about obese persons [Electronic version]. *International Journal of Eating Disorders, 10*, 599-607.

American Medical Association (2015). *Recognition of obesity as a disease*. H-440.842. Retrieved 10th March from www.ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HnE/H-440.842.HTM

Amy, N. K., Aalborg, A., Lyons, P. & Keranen, L. (2006). Barriers to routine gynaecological cancer screening for White and African-American obese women [Electronic version]. *International Journal of Obesity (Lond), 30* (1), 147-155.

Anderson, J., Konz, E., Frederick, R. & Wood, C. (2001). Long-term weight-loss maintenance: A meta- analysis of US studies [Electronic version]. *American Journal of Clinical Nutrition, 74*, 579–584.

Anderson, D. A. & Wadden, T. A. (2004). Bariatic Surgery patient's view of their physicians; weight-related attitudes and practices [Electronic version]. *Obesity Research, 12* (10), 1587-1595.

Antonovsky, A. (Ed.) (1985). *Health stress and coping*. San Francisco: Jossey Bass.

Antonovsky, A. (1987)*. Unravelling the mystery of health: how people manage stress and stay well*. San Francisco: Jossey Bass.

Apovian, C. A., Garvey, W. T. & Ryan, D. H. (2015). Challenging Obesity: Patient, Provider, and Expert Perspectives on the Roles of Available and Emerging Nonsurgical Therapies [Electronic version]. *Obesity, 23* (2), S1-S26.

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research [Electronic version]. *Qualitative Research, 1* (3), 385-405.

Aveyard, P., Johnson, C., Fillingham, S., Parsons, A. & Murphy, M. (2008). A pragmatic randomised controlled trial of nortriptyline plus nicotine replacement versus placebo plus nicotine replacement for smoking cessation [Electronic Version]. *BMJ, 336*, 1223-7.

Ballantyne, G. H. (2003). Measuring outcomes following bariatric surgery: weight loss parameters, improvement in co-morbid conditions, change in quality of life and patient satisfaction [Electronic version]. *Obesity Surgery 13*, 954–964.

Bandura, A. (Ed.) (1997). *Self-efficacy: the exercise of control*. New York: Freeman.

Bandura, A. & Schunk, D. H. (1981). Cultivating competence, self-efficacy, and intrinsic interest through proximal self-motivation [Electronic version]. *Journal of Personality and Social Psychology, 41*, 586-598.

Barr, S. I., Yarker, K. V., Levy-Milne, R. & Chapman, G. E. (2004). Canadian dieticians' view and practices regarding obesity and weight management [Electronic version]. *Journal of Human Nutrition and Dietetics, 17*, 503-512.

Bassey, M. (1981). Pedagogic research: on the relative merits of search for generalisation and study of single events [Electronic version]. *Oxford Review of Education, 7*, 73-93.

Bauer, M. W. & Gaskell, G. (2000). *Qualitative researching with text, image and sound: a practical handbook*. London: Sage.

Becker, M. (1974). Health belief model and personal health behavior [Electronic version]. *Health Education Monographs. 2*, 324-473.

Bestermann, W. H. (2010). Incorporating practical lifestyle management for obesity [Electronic version]. *The Journal of Family Practice, 59* (5), S3-S8.

Bidgood, J. & Buckroyd, J. (2005). An exploration of obese adults' experience of attempting to lose weight and to maintain a reduced weight [Electronic version]. *Counselling and Psychotherapy Research, 5* (3), 221-229.

Bjornson, W. (2000). Strategic partnerships for addressing tobacco use [Electronic version]. *Tobacco Control, 9,* 167-70.

Blackburn, G. (1995). Effect of degree of weight loss on health benefits [Electronic version]. *Obesity Research, 3* (2), 211S–6S.

Bleich, S., & Blendon, R. (2011). Public opinion and obesity. In R. Blendon., M. Brodie., D. E. Altman., & J. Benson (Ed.) *American public opinion and health care* (pp. 346-367). Washington, DC: CQ Press.

Blount, A. (2003). Integrated Primary Care: Organizing the Evidence [Electronic version]. *Families, Systems & Health, 21,* 121-134.

Bourdieu, P. (1977). *Outline of a Theory of Practice*. Cambridge and New York: Cambridge University Press.

Bourdieu, P. (1986). The forms of capital. In J. Richardson (Ed.) *Handbook of theory and research for the sociology of education.* New York: Greenwood Press.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology [Electronic version]. *Qualitative Research in Psychology, 3,* 83.

Brewer, J. & Hunter, A. (1989). *Multimethod research: a synthesis of styles.* Newbury Park: Sage Library of Social Research Series, Vol. 175.

Bridle, C., Riemsma, R. P., Pattenden, J., Sowden, A. J., Mather, L., Watt, I. S. & Walker, A. (2005). Systematic review of the effectiveness of health behavior interventions based on the transtheoretical model [Electronic version]. *Psychology and Health, 20* (3), 283–301

Brown, I., Thompson, J., Tod, A. & Jones, G. (2006). Primary Care support for tackling obesity: a qualitative study of the perceptions of obese patients [Electronic version]. *British Journal of General Practice, 56* (530), 666-672.

Brownell, K. D. (2010). The humbling experience of treating obesity: Should we persist or desist? [Electronic version]. *Behaviour Research and Therapy, 48*, 717-719.

Brownell, K. D., Kersh, R., Ludwig, D. S., Post, R. C., Puhl, R. M., Schwartz, M. B. & Willett, W. C. (2010). Personal responsibility and obesity: a constructive approach to a controversial issue [Electronic version]. *Health Affairs (Millwood), 29* (3), 379-87.

Brownell, K. D. & Rodin, J. (1994). The dieting maelstrom. Is it possible and advisable to lose weight? [Electronic version]. *The American Psychologist, 49* (9), 781-91.

Burdett, T. M. (2010). *Being connected: An exploration of women's weight loss experience and the implications for health education.* Unpublished Doctoral Thesis, University of Southampton, School of Education.

Burnet, D.L., Elliott, L. D., Quinn, M. T., Plaut, A. J., Schwartz, M. A. & Chin, M. H. (2006). Preventing diabetes in the clinical setting [Electronic version]. *Journal of General Internal Medicine, 21*, 84-93.

Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.

Butland, B., Jebb, S., Kopelman, P., McPherson, K., Thomas, S., Mardell, J. & Parry, V. (Eds.) (2007). *Tackling obesities: future choices – project report*. London: Foresight Programme of the Government Office for Science.

Cabezas. C., Advani. M., Puente. D., Rodriguez-Blanco., T, Martin, C. & ISTAPS study group. (2011). Effectiveness of a stepped primary care smoking cessation intervention: cluster randomized clinical trial (ISTAPS study) [Electronic version]. *Addiction, 106*, 1696-1706.

Cade, J. & O'Connell, S. (1991). Management of weight problems and obesity: knowledge, attitudes and current practice of general practitioners [Electronic version]. *British Journal of General Practice, 41,* 147-150.

Carlson, C. L., Chute, P., Dacey, S. & McAfee, T. A. (2000). Designing tobacco control systems and cessation benefits in managed care: skill-building workshop [Electronic version]. *Tobacco Control, 9*, 125-129.

Centers for Disease Control and Prevention (1999). *Best practices for comprehensive tobacco control programs.* Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

Connolly, M., Deaton, C., Dodd, M., Grimshaw, J., Hulme, T., Everitt, S. & Tierney, S. (2010). Discharge preparation: Do healthcare professionals differ in their opinions? [Electronic version]. *Journal of Interprofessional Care, 24* (6), 633–643.

Conner, M. & Sparks, P. (2005). Theory of planned behaviour and health behaviour. In M. Conner & P. Norman (Ed.) *Predicting health behaviour: Research and practice with social cognition models*. Maidenhead: Open University Press.

Cooper, Z., Doll, H. A., Hawker, D. M., Byrne, S., Bonner, G., Eeley, E., O'Connor, M. E. & Fairburn, C. G. (2010). Testing a new cognitive behavioural treatment for

obesity: A Randomized controlled trial with three-year follow-up. *Behaviour Research and Therapy, 48,* 706-713.

Cooper, Z. & Fairburn, C. G. (2001). A new cognitive behavioural approach to the treatment of obesity [Electronic version]. *Behaviour Research and Therapy, 39*, 499-511.

Cooper, Z. & Fairburn, C. G. (2002). Cognitive-behavioural treatment of obesity. In T. A. Wadden., & A. J. Stunkard (Eds.) (2002). *Handbook of Obesity treatment* (pp.465-479). New York, NY: Guildford Press.

Craighead, L. W., Stunkard, A. J. & O'Brien, R. M. (1981). Behavior therapy and pharmacotherapy for obesity [Electronic version]. *Archives of General Psychiatry, 38* (7), 763–768.

Cullen, C. (2015). *Maintained Weight Loss: Barriers and Facilitators*. Unpublished doctoral thesis, University of Wolverhampton.

Curioni, C. C. & Lourenco, P. M. (2005). Long-term weight loss after diet and exercise: a systematic review [Electronic version]. *International Journal of Obesity, 29*, 1168–1174.

Davidson, M. B. (2001). The disproportionate burden of diabetes in African-American and Hispanic populations [Electronic version]. *Ethnicity & Disease, 11*, 148-151.

Davis-Coelho, K., Waltz, J. & Davis-Coelho, B. (2000). Awareness and prevention of bias against fat clients in psychotherapy [Electronic version]. *Professional Psychology: Research and Practice, 31*, 682-684.

DeJong, W. (1980). The stigma of obesity: the consequences of naive assumptions concerning the causes of physical deviance [Electronic version]. *Journal of Health and Social Behaviour, 21* (1), 75–87.

Department of Health and Central Office of Information. (2006). *Your weight, your health.* London: Department of Health Central Office of Information, 1-32.

Di Clemente, C. C. & Prochaska, J. O. (1982). Self-change and therapy change of smoking behaviour: a comparison of processes of change in cessation and maintenance [Electronic version]. *Addictive Behaviours, 7*, 133-42.

Duffy, M. (1990). 'Counselling Psychology USA: Patterns of continuity and change'. *Counselling Psychology Review, 5* (3), 9-18.

Eggar, G. & Swinburn, B. (2002). Preventative Strategies against Weight Gain and Obesity [Electronic version]. *Obesity Reviews*, *3*, 28–301.

Elfhag, K. & Rossner, S. (2005). Who succeeds in maintaining weight loss? A conceptual review of factors associated with weight loss maintenance and weight regain [Electronic version]. *Obesity Reviews, 6*, 67-85.

Ely, M., Vinz, R., Downing, M. & Anzul, M. (1997). *On writing qualitative research: Living by words*. London: Routledge/Falmer.

Epstein, L. & Ogden, J. (2005). A qualitative study of GP's views of treating obesity [Electronic version]. *British Journal of General Practice, 55,* 750-754.

E-Therapy for eating disorders (CBTe). Retrieved 15th October from www.credo-oxford.com/5.1.html

Ezzy, D. (2002) *Qualitative Analysis: practice and innovation.* London: Routledge.

Fairburn, C. G., Cooper, Z., Doll, H. A., O'Connor, M. E., Bohn, K., Hawker, D. M., Wales, J. A. & Palmer, R. L. (2009). Transdiagnostic cognitive-behavioral therapy for patients with eating disorders: A two-site trial with 60-week follow-up [Electronic version]. *American Journal of Psychiatry, 166*, 311-319.

Fairburn, C. G., Cooper, Z. & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment [Electronic version]. *Behaviour Research and Therapy, 41*, 509-528.

Fairburn, C. G., Cooper, Z., Doll, H. A., Palmer, R.L. & Dalle Grave, R. (2013). Enhanced cognitive behaviour therapy for adults with anorexia nervosa: a UK-Italy study [Electronic version]. *Behaviour Research and Therapy, 51*, R2-R8.

Feste, C. & Andersson, R. M. (1995). Empowerment from philosophy to practice [Electronic version]. *Patient Education and Counseling, 26*, 139-144.

Fildes, A., Charlton, J., Rudisill, C., Littlejohns, P., Prevost, T. & Gulliford, M. C. (2015). Probability of an Obese Person Attaining Normal Body Weight: Cohort Study Using Electronic Health Records [Electronic Version]. *Research and Practice, 105* (9), e54-e59.

First International Conference on Health Promotion (1986). The Ottawa charter for health promotion [Electronic version]. *Health Promotion, 1,* 1-5.

Fishbein, M., Hall-Jamieson, K., Zimmer, E., Von Haeften, I. & Nabi, R. (2002). Avoiding the boomerang: testing the relative effectiveness of antidrug public service announcements before a national campaign [Electronic version]. *American Journal of Public Health, 92* (2), 238-245.

Fogelman, Y., Vinker, S., Lachter, J., Biderman, A., Itzhak, B. & Kitai, E. (2002). Managing obesity; a survey of attitudes and practices among Israeli primary care physicians [Electronic version]. *International Journal of Obesity and Related Metabolic Disorders, 26*, 1393-1397.

Foresight. (2007). *Tackling obesities: future choices – project report.* London: Government Office for Science

Foster, G., Dadden, T. A., Makris, A. P., Davidson, D., Sanderson, R. S., Allison, D. B. & Kessler, A. (2003). Primary Care Physician's Attitudes about Obesity and it's Treatment [Electronic version]. *Obesity Research, 11* (10), 1168-1177.

Friedman. K., Ashmore. J. & Applegate, K. (2008). Recent experiences of weight-based stigmatization in a weight loss surgery population: psychological and behavioral correlates [Electronic version]. *Obesity, 16,* S69-74.

Garip, G. & Yardley, L. (2011). A synthesis of qualitative research on overweight obese people's views and experiences of weight management [Electronic version]. *Clinical Obesity*, 1 (2-3), 110-126.

Garvey, W. T., Garber, A. J., Mechanick, J. I., Bray, G. A., Dagogo-Jack, S., Einhorn, D., Grunberger, G., Handelsman, Y., Hennekens, C. H., Hurley, D. L., McGill, J., Palumbo, P., Umpierrez, G. & On Behalf Of The Aace Obesity Scientific Committee. (2014). American Association of Clinical Endocrinologists and American College of Endocrinology consensus conference on obesity: building an evidence base for comprehensive action [Electronic version]. *Endocrine Practice, 20*, 956-976.

Giddens, A. (1979). *Central problems in social theory: action, structure and contradiction in social analysis*. Berkeley: University of California Press.

Giddens, A. (1982). *Profiles and critiques in social theory*. London: Macmillan. Retrieved 10th January from www.books.google.co.uk/books?hl=en&lr=&id=n2j1bl4AJj4C&oi=fnd&pg=PR7&dq=

Giddens,+A.+(1982).+Profiles+and+critiques+in+social+theory.+London:+Macmillan.&ots=ttKZXdB037&sig=i_4Yb8v4uSgTJZPMFVpyS5BHjI#v=onepage&q=Giddens%2C%20A.%20(1982).%20Profiles%20and%20critiques%20in%20social%20theory.%20London%3A%20Macmillan.&f=false

Giddens, A. (1984). *The constitution of society: outline of the theory of structuration*. Berkeley: University of California Press. Retrieved 20th January from www.books.google.co.uk/books?hl=en&lr=&id=x2bf4g9Z6ZwC&oi=fnd&pg=PR9&dq=Giddens,+A.+(1984).+The+constitution+of+society:+outline+of+the+theory+of+structuration.+Berkeley:+University+of+California+Press.&ots=jMYK6trx7A&sig=u4oqHqCEw_u8Zy8nvtY8Q9IHFMM#v=onepage&q=Giddens%2C%20A.%20(1984).%20The%20constitution%20of%20society%3A%20outline%20of%20the%20theory%20of%20structuration.%20Berkeley%3A%20University%20of%20California%20Press.&f=false

Goldstein, D. J. (1992). Beneficial health effects of modest weight loss [Electronic version]. *International Journal of Obesity and Related Metabolic Disorders, 16*, 397-415.

Graneheim, U. & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*, 105-112.

Greenhalgh, T. (1997). How to read a paper: Assessing the methodological quality of published papers [Electronic Version]. *BMJ, 315*, 305-308.

Griffiths, C. A., Ryan, P. & Foster, J. H. (2011). Personality and Social Psychology. Thematic analysis of Antonovsky's sense of coherence theory [Electronic version]. *Scandinavian Journal of Psychology, 52,* 168-173.

Grzywacz, J. G. & Fuqua, J. (2000). The social ecology of health. Leverage points and linkages [Electronic version]. *Behavioural Medicine. 26*, 101-115.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries [Electronic version]. *Educational Communication and Technology Journal, 29*, 75-91.

Gupta, H. (2014). Barriers to and Facilitators of Long Term Weight Loss Maintenance in Adult UK People: A Thematic Analysis [Electronic version]. *International Journal of Preventative Medicine, 5* (12), 1512-1520.

Haines, A. & Jones, R. (1994). Implementing finding of research [Electronic version]. *British Medical Journal*, 308, 1488-92.

Hawley, J. A. & Lessard, S. J. (2008). Exercise training-induced improvements in insulin action [Electronic version]. *Acta Physiologica, 192* (1), 127–135,

Heron, K. E. & Smyth, J. M. (2010). Ecological Momentary Interventions: Incorporating Mobile Technology into Psychosocial and Health Behavior Treatments [Electronic version]. *British Journal of Health Psychology, 15* (1), 1-39.

Herriot, A. M., Thomas, D. E., Hart, K. H., Warren, J. & Truby, H. (2008). A qualitative investigation of individuals' experiences and expectations before and after completing a trial of commercial weight loss programmes [Electronic version]. *Journal of Human Nutrition and Dietetics, 21*, 72-80.

Hertz, R. P., Unger, A. N. & Ferrario, C. M. (2006). Diabetes, hypertension, and dyslipidemia in Mexican Americans and non-Hispanic Whites [Electronic version]. *American Journal of Preventive Medicine, 30,* 103–110

Higgins, S. T., Budney, A. J., Bickel, W. K., Foerg, F. E., Donham, R. & Badger, G. J. (1994). Incentives improve outcome in outpatient behavioral treatment of cocaine dependence [Electronic version]. *Archives of General Psychiatry, 51*, 568–576.

Hojjat, T. A. (2015). The Economic Analysis of Obesity [Electronic version]. *Review of Business & Finance Studies, 6* (1), *81-98.*

Hollywood, A. & Ogden, J. (2010). Taking Orlistat: Predicting Weight Loss over 6 months [Electronic version]. *Journal of Obesity, 2011*, 1-7.

Holloway, I. & Todres, L. (2003). The status of method: flexibility, consistency and coherence [Electronic version]. *Qualitative Research, 3* (3), 345-357**.**

House of Commons Health Committee (2004). *Obesity: Third Report of Session 2003/4.* London: The Stationery Office.

INVOLVE for a stronger democracy. Retrieved 10th June from *www.involve.org.uk/*

Jeffrey, R. W., Drewnowski, A., Epstein, L. H., Stunkard, A. J., Wilson, G. T. & Wing, R. R. (2002). Long term maintenance of weight loss: Current Status [Electronic version]. *Health Psychology, 19* (1), 5-16.

Jia, H. & Lubetkin, E. I. (2010). Obesity-related quality-adjusted life years lost in the U.S. from 1993 to 2008 [Electronic version]. *American Journal of Preventative Medicine, 39* (3), 220-7.

Jolly, K., Lewis, A., Beach, J., Denley, J., Adab, P., Deeks, J. J., Daley, A. & Aveyard, P. (2011). Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten Up randomised controlled trial [Electronic Version]. *BMJ, 343*, 1-26.

Jones, M., Grilo, C. M., Masheb, R. M. & White, M. A. (2010). Psychological and Behavioural Correlates of Excess Weight: Misperception of Obese Status Among Persons with Class II Obesity [Electronic version]. *International Journal of Eating Disorders, 43* (7), 628-632.

Karlsson, J., Sjostrom, L. & Sullivan, M. (1998). Swedish obese subjects (SOS) – an intervention study of obesity. Two-year follow-up of health-related quality of life (HRQL) and eating behavior after gastric surgery for severe obesity [Electronic version]. *International Journal of Obesity on Related Metabolic Disorders, 22*, 113–126.

Kelly, T., Yang W., Chen, C. S., Reynolds, K. T. & He, J. (2008). Global burden of obesity in 2005 and projections to 2030. *International Journal of Obesity (Lond), 32* (9), 1431-7.

Koch, T. & Harrington, A. (1998). Reconceptualising rigour: the case for reflexivity. *Journal of Advanced Nursing, 28* (4), 882-890.

Koeck, C. (1998). Time for organizational development in healthcare organizations. Improving quality for patients means changing the organization [Electronic version]. *British Medical Journal, 317,* 1267-1268.

Kopelman, P. (2001). Developing an action plan for obesity education [Electronic version]. *International Journal of Obesity and Related Metabolic Disorders, 4,* 16-19.

Kristeller, J. L. & Hoerr, R. A. (1997). Physician attitudes towards managing obesity: differences a speciality groups [Electronic version]. *Preventative Medicine, 26*, 542-549.

Kulik, J. A. & Mahler, H. I. M. (1993). Emotional Support as a Moderator of Adjustment and Compliance after Coronary Artery Bypass Surgery: A Longtitudnal Study [Electronic version]. *Journal of Behavioral Medicine, 16* (1), 45-63.

Kushner, R. & Pendarvis, L. (1999). An Integrated Approach to Obesity Care [Electronic version]. *Nutrition in Clinical Care, 2* (5), 285-291.

Latner, J. D., Durso, L. E. & Mond, J. M. (2013). Health and health-related quality of life among treatment-seeking overweight and obese adults: associations with internalized weight bias [Electronic version]. *Journal of Eating Disorders, 1* (3), 1-6.

Lazarus, R. (Ed.) (1976). *Patterns of adjustment*. New York: McGraw Hill.

Lazarus, R. S. (1985). The costs and benefits of denial. In A. Monat & R. Lazarus (Ed.) *Stress and coping: an anthology*. New York: Columbia University Press.

Lazarus, R. & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

Lean, M. E. J., Han, T. S. & Morrison, C. E. (1995). Waist circumference as a measure for indicating need for weight management [Electronic version]. *British Medical Journal, 311*, 158-61

LeGrange, D., Gorin, A., Dymek, M. & Stone, A. (2002). Does ecological momentary assessment improve cognitive behavioural therapy for binge eating disorder? A pilot study [Electronic version]. *European Eating Disorders Review, 10,* (5), 316–328.

Lehl, S. (2012). *The Importance of Counselling and Psychological support in Obesity and Weight Management Services.* A Critical Review of the Literature. Unpublished, University Of Wolverhampton.

Lehnert, T., Sonntag, D., Konnopka, A., Riedel-Heller, S. & König, H. H. (2013). Economic costs of overweight and obesity [Electronic version]. *Best Practice & Research Clinical Endocrinology & Metabolism, 27*, 105–115.

Leverence, R. R., Williams, R. L., Sussman, A., Crabtree, B. F. & RIOS Net Clinicians. (2007). Obesity counselling and guidelines in primary care: a qualitative study [Electronic Version]. *American Journal of Preventive Medicine, 32*, 334-9.

Li, C., Ford, E. S., Lisa C. McGuire, L. C. & Mokdad, A. H. (2007). Increasing trends in waist circumference and abdominal obesity among U.S. adults [Electronic version]. *Obesity, 15*, 216-223.

Liburd, L. C. & Vinicor, F. (2003). Rethinking diabetes prevention and control in racial and ethnic communities [Electronic version]. *Journal of Public Health Management Practice, 9*, S74-S79.

Lifestyle Statistics Team, Health and Social Care Information Centre (2015). *Statistics on Obesity, Physical Activity and Diet: England.* National Statistics.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills: Sage.

Lindekilde, N., Gladstone, B. P., Lübeck, M., Nielsen, J., Clausen, L., Vach, W. & Jones, A. (2015). The impact of bariatric surgery on quality of life: a systematic review and meta-analysis [Electronic version]. *Obesity Reviews, 16* (8), 639-51.

MacInness, D. L. & Lewis, M. (2008). The evaluation of a short group programme to reduce self-stigma in people with serious and enduring mental health problems [Electronic version]. *Journal of Psychiatric and Mental Health Nursing, 15* (1), 59-65.

Magallaresa, A. & Schomerus, G. (2014). Mental and physical health-related quality of life in obese patients before and after bariatric surgery: A meta-analysis [Electronic version]. *Psychology, Health & Medicine, 20* (2), 165-176.

Maggard, M. A., Shugarman, L. R., Stuttorp, M., Maglione, M., Sugerman, H. J., Livingstone, E. H., Nguyen, N. T., Li, Z., Mojica, W. A., Hilton, L., Rhodes, S., Morton, S. C. & Shekelle, P. G. (2005). Meta-analysis: surgical treatment of obesity. *Annals of Internal Medicine, 142* (7), 547-59.

Mamplekou, E., Komesidou, V., Bissias, Ch., Papakonstantinou, A. & Melissas, J. (2005). Psychological condition and quality of life in patients with morbid obesity before and after surgical weight loss [Electronic version]. *Obesity Surgery, 15* (8), 1177-84.

Mann, T., Tomiyama, A. J., Westling, E., Lew, A. M., Samuels, B. & Chatman, J. (2007). Medicare's search for effective obesity treatments: diets are not the answer [Electronic version]. *American Psychologist, 62* (3), 220-33.

Marlatt, G. & Gordon, J. R. (1980). Determinants of relapse. implications for the maintenance of behavior change. In P. O. Davidson., & S. M. Davidson (Ed.) *Behavioral Medicine: Changing Health Lifestyles* (pp.410-452). Brunner/Mazel New York.

Marlatt, G. & Gordon, J. R. (Ed.) (1985). *Relapse Prevention. Maintenance Strategies in the Treatment of Addictive Behaviors*. New York, NY: The Guilford Press.

Mastellos, N., Gunn, L. H., Felix, L. M., Car, J. & Majeed, A. (2014). Transtheoretical model stages of change for dietary and physical exercise modification in weight loss management for overweight and obese adults (Review) [Electronic version]. *The Cochrane Library, 2*, 1-4.

McEwen, A., West, R. & McRobbie, H. (2006). Effectiveness of specialist group treatment for smoking cessation vs. one-to-one treatment in primary care. *Addictive Behaviors, 31*, 1650-60.

McLean, N., Griffin, S., Toney, K. & Hardeman, W. (2003). Family involvement in weight control, weight maintenance and weight-loss interventions: a systematic review of randomised trials [Electronic Version]. *International Journal of Obesity, 27*, 987-1005.

McLeod, J. (Ed). (2001). *Qualitative research in counselling and psychotherapy*. London: Sage.

McLeroy, K. R., Bibeau D., Steckler A. & Glanz K. (1988). An ecological perspective on health promotion programs [Electronic version]. *Health Education Quarterly. 15*, 351-377.

Melin, I., Karlstrom, B., Berglund, L., Zamfir, M. & Rossner, S. (2005). Education and supervision of health care professionals to initiate implement and improve management of obesity [Electronic version]. *Patient Education and Counselling, 58*, 127-136.

Mercer, S. L., Green, L. W., Rosenthal, A. C., Husten, C. G., Khan, L. K. & Dietz, W. H. (2003). Possible lessons from the tobacco experience for obesity control. [Electronic version]. *American Journal of Clinical Nutrition, 77*, 1073-1082.

Merriam, S. (1998). *Qualitative research and case study applications in education.* San Francisco, CA: Jossey-Bass.

Milio, N. (1976). A framework for prevention: changing health-damaging to health-generating life patterns [Electronic version]. *American Journal of Public Health, 66*, 435-439.

Miller, N. H., Hill, M., Kottke, T. & Ockene, I. S. (1997). The multilevel compliance challenge recommendations for a call to action [Electronic version]. A statement for healthcare professionals. *Circulation. 95*, 1085-1090.

Milne, D. I., Baker, C., Blackburn, I. M., James, I. & Reichelt, K. (1999). Effectiveness of cognitive therapy training [Electronic version]. *Journal of Behaviour Therapy and Experimental Psychiatry, 30*, 81-92.

Minniti, A., Bissoli, L., Di Francesco, V., Fantin, F, Mandragona, R., Olivieri, M., Fontana, G., Rinaldi, C., Bosello, O. & Zamboni, M. (2007). Individual versus group therapy for obesity: Comparison of dropout rate and treatment outcome [Electronic version]. *Eating and weight disorders: EWD, 12* (4), 161-167.

Miyazaki, A. D. & Taylor, K. A. (2008). Researcher Interaction Biases and Business Ethics Research: Respondent Reactions to Researcher Characteristics [Electronic version]. *Journal of Business Ethics, 81*, 779-795.

Mokdad, A. H., Ford, E. S., Bowman, B. A. & Nelson, D. E. (2000). Diabetes trends in the U.S: 1990-1998 [Electronic version]. *Diabetes Care, 23*, 1278-1283.

Mokdad, A. H., Marks, J.S., Stroup, D. F. & Gerberding, J. L. (2004). Actual causes of death in the United States [Electronic version]. *JAMA, 291*, 1238–1245.

Molinari, E., Baruffi, M., Croci, M., Marchi, S. & Petroni, M. L. (2005). Binge eating disorder in obesity: Comparison of different therapeutic strategies [Electronic version]. *Eating and weight disorders: EWD, 10* (3), 154-161.

Morgan, A. & Swann, C. (2004). *Social capital for health: issues of definition, measurement and links to health.* London: Health Development Agency.

Morse, J. M., Barrett, M., Mayan, M., Olson, K. & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1* (2), 1-19.

Moustakas, C. (1990). *Heuristic Research: Design, Methodology and Applications.* Newbury Park. CA: Sage.

Mussell, M. P., Mitchell, J. E., De Zwaan, M., Crosby, R. D., Seim, H. C. & Crow, S. J. (1996). Clinical characteristics associated with binge eating in obese females: a descriptive study [Electronic version]. *International Journal of Obesity, 20,* 324-331.

Nackers, L. M., Ross, K. M., & Perri, M. G. (2010). The association between rate of initial weight loss and long-term success in obesity treatment: does slow and steady win the race? [Electronic version]. *International Journal of Behavioral Medicine, 17* (3), 161-7.

National Audit Office. (2001). *Tackling Obesity in England*. London: The Stationery Office.

National Obesity Observatory. (2011). *Obesity and Ethnicity*. Solutions for Public Health.

Narbro, K. (1997). Sick leave and disability pension before and after treatment of Obesity. In J. Ostman., M. Britton. & E. Jonsson. (Ed.) *Treating and Preventing Obesity: An Evidence Based Review.* WILEY-VCH. Retrieved 15th May from www. books.google.co.uk/books?id=5NDdg7gm5yYC&printsec=frontcover&dq=Treating+and+Preventing+Obesity:+An+Evidence+Based+Review&hl=en&sa=X&ved=0ahUKEwjv__KPh5jKAhXI1A4KHSEkCnoQ6AEIFDAA#v=onepage&q=Treating%20and%20Preventing%20Obesity%3A%20An%20Evidence%20Based%20Review&f=false

National Institute for Health and Clinical Excellence (2006). *Obesity. Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children.* National Institute for Health and Clinical Excellence, London.

National Institute for Health and Care Excellence. (2007). *Behaviour change: the principles for effective interventions. Public Health Guidance 6*. National Institute for Health and Clinical Excellence, London. Retrieved 13th May from www.nice.org.uk/guidance/ph6

National Institute for Health and Care Excellence. (2008). *Stop smoking services. Public Health Guidance 10*. National Clinical Guideline Centre. Retrieved 14th May from www.nice.org.uk/guidance/ph10

National Institute for Health and Care Excellence. (2014). *Managing overweight and obesity in adults – lifestyle weight management services. Public Health Guidance 53.* National Institute for Health and Clinical Excellence, London. Retrieved 10th May from www.nice.org.uk/guidance/ph53

National Institute for Health and Care Excellence. (2014). *Obesity. Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children*. *Guideline CG189*. National Institute for Health and Clinical Excellence, London. Retrieved 15th May from www.nice.org.uk/guidance/CG189

National Institute for Health and Care Excellence. (2014). *Obesity. Identification, assessment and management of overweight and obesity in children, young people and adults. Partial update of Guidance CG43. Methods, evidence and recommendations.* National Clinical Guideline Centre. Retrieved 12th May from www.nice.org.uk/guidance/CG43

Newson, L. & Flint, B. (2011). Applied Psychology and Obesity Management. In The British Psychological Society Professional Practice Board. *Obesity in the UK: A Psychological Perspective* (Rev. edn., pp.26-38). The Obesity Working Group.

Nicholls, W., Devonport, T.J. & Blake, M. (2016). The association between emotions and eating behaviour in an obese population with binge eating disorder [Electronic version]. *Obesity Reviews, 17 (1), 30-42.*

Obesity and Overweight Fact Sheet (2013). World Health Organisation Media Centre. Retrieved 15th July from www.who.int/mediacentre/factsheets/fs311/en/index.html

Ockene J. & Ockene I. (1992). Helping patients to reduce their risk for coronary heart disease. an overview. In I. S. Ockene & J. Ockene (Ed.) *Prevention of Coronary Heart Disease (pp. 173-199).* Little, Brown and Company Boston, MA.

Ogden, J., Bandara, I., Cohen, H., Farmer, D., Hardie, J., Minas, H., Moore, J., Quershi, S., Walter, F. & Whitehead, M. (2001). GP's and patients models of obesity: whose problem is it anyway? [Electronic version]. *Patient Education and Counselling, 40*, 227-233.

Ogden, J. & Sidhu, S. (2006). Adherence, behaviour change, and visualisation: a qualitative study of the experiences of taking an obesity medication [Electronic version]. Journal of *Psychosomatic Research, 61*, 545-552.

Ohsiek, S. & Williams, M. (2011). Psychological factors influencing weight loss maintenance: an integrative literature review [Electronic version]. *Journal of the American Academy* of *Nurse Practitioners,* 23, 592–601.

Okosun, I.S., Chandra, K. M. D., Boev, A., Boltri, J. M., Choi, S. T., Parish, D. C. & Dever, G. E. A. (2004). Abdominal adiposity in U.S. adults: prevalence and trends, 1960-2000 [Electronic version]. *Preventive Medicine, 39*, 197-206.

O'Meara, S., Glenny. A. M., Wilson, C., Melville, A. & Sheldon, T. A. (1997). Effective management of obesity [Electronic version]. *Quality in Health Care, 6*, 170-175.

O'Reilly, G. A., Cook, L., Spruijt-Metz, D. & Black, D. S. (2014). Mindfulness-Based Interventions for Obesity-Related Eating Behaviors: A Literature Review [Electronic version]. *Obesity Reviews, 15* (6), 453-461.

Oster, G., Harding, G., Dukes, E., Edelsberg, J. & Cleary, P.D. (2005). Pain, Medication Use, and Health-Related Quality of Life in Older Persons with Postherpetic Neuralgia: Results from a Population-Based Survey [Electronic version]. *Journal of Pain, 6* (6), 356-363.

Oyebode, O. & Mindell, J. (2013). Use of data from the Health Survey for England in obesity policy making and monitoring [Electronic version]. *Obesity Reviews, 14* (6), 463-476.

Pannucci, C. J. & Wilkins, E. G. (2010). Identifying and avoiding bias in research [Electronic version]. *Plastic and Reconstructive Surgery*, *126* (2), 619–625

Patton, M. Q. (Ed). (1990). *Qualitative evaluation and research methods.* Newbury Park, CA: Sage.

Pearl, R. L. & Lebowitz, M. S. (2014). Beyond personal responsibility: Effects of causal attributions for overweight and obesity on weight-related beliefs, stigma, and policy support [Electronic version]. *Psychology and Health, 29* (10), 1176-1191.

Pearl, R. L., White, M. A. & Grilo, C. M. (2014). Weight bias internalization, depression, and self-reported health among overweight binge eating disorder patients [Electronic version]. *Obesity, 22,* 142-148.

Picot, J., Jones, J., Colquitt, J. L., Gospodarevskaya, E., Loveman, E., Baxter, L. & Clegg, A.J. (2009). The clinical effectiveness and cost-effectiveness of bariatric (weight loss) surgery for obesity: a systematic review and economic evaluation [Electronic version]. *Health Technology Assessment , 13* (41), 1-214.

Polivy, J. & Herman, C. P. (1985). Dieting and binging [Electronic version]. *American Psychologist, 40*, 193-201.

Pollak, K. I., Ostbye, T., Alexander, S. C., Gradison. M., Bastian. L. A., Brouwer, R. J. N. & Lyna, P. (2007). Empathy goes a long way in weight loss discussions [Electronic version]. *The Journal of Family Practice, 56* (12), 1031-1036.

Pomeranz, J. L. (2008). A historical analysis of public health, the law, and stigmatized social groups: the need for both obesity and weight bias legislation [Electronic version]. *Obesity (Silver Spring), 16*, S93-S102.

Poulsen, S., Lunn, S., Daniel, S. I. F., Folke, S., Mathiesen, B. B., Katznelson, H. & Fairburn C.G. (2014). A randomized controlled trial of psychoanalytical psychotherapy versus cognitive behavior therapy for bulimia nervosa [Electronic version]. *American Journal of Psychiatry, 171*, 109-116.

Povey, R., Conner, M., Sparks, P., James, R. & Shepherd, R. (1999). A critical examination of the application of the transtheoretical model's stages of change to dietary behaviors [Electronic version]. *Health Education Research, 14*, 641–651.

Prochaska, J. O. & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change [Electronic version]. *Journal of Consulting and Clinical Psychology, 51*, 390–395.

Puhl, R. & Brownell, K. D. (2001). Bias, Discrimination, and Obesity [Electronic version]. *Obesity Research, 9*, 788-805.

Puhl, R. M. & Brownell, K. D. (2003). Psychosocial origins of obesity stigma: Toward changing a powerful and pervasive bias [Electronic version]. *Obesity Reviews, 4*, 213-227.

Puhl, R. M. & Heuer, C. A. (2010). Obesity stigma: Important considerations for public health [Electronic version]. *American Journal of Public Health, 100*, 1019-1028.

Puhl. R. & Latner. J. (2007). Stigma, obesity, and the health of the nation's children [Electronic version]. *Psychological Bulletin, 133*, 557-80.

Puhl, R., Peterson, J. L. & Luedicke, J. (2012). Fighting obesity or obese persons? Public perceptions of obesity-related health messages [Electronic version]. *International Journal of Obesity,* 1-9.

Putnam, R. D. (2000). *Bowling alone: the collapse and revival of American community*. New York: Simon & Schuster. Retrieved 30th April from

Ratcliffe, D. & Ellison, N. (2013). Obesity and Internalized Weight Stigma: A Formulation Model for an Emerging Psychological Problem [Electronic version]. *Behavioural and Cognitive Psychotherapy, 43,* 239-252.

Razavi, D. & Delvaux, N. (1997). Communication Skills and Psychological Training in Oncology [Electronic version]. *European Journal of Cancer, 33* (6), 15-21.

Reba-Harrelson, L., Von Holle, A., Thornton, L. M., Klump, K. L., Berrettini, W. H., Brandt, H., Crawford, S., Crow, S., Fichter, M. M., Goldman, D., Halmi, K. A., Johnson, C., Kaplan, A. S., Keel, P., LaVia, M., Mitchell, J., Plotnicov, K., Rotondo, A., Strober, M., Treasure, J., Woodside, D., Kaye, W. H. & Bulik, C. M. (2008). Features associated with diet pill use in individuals with eating disorders [Electronic version]. *Eating Behaviors, 9 (1*), 73–81.

Reicher, S. & Taylor, S. (2005). Similarities and differences between traditions [Electronic version]. *The Psychologist, 18* (9), 547-549.

Renjilian, D. A., Perri, M. G., Nezu, A. M., McKelvey, W. F., Shermer, R. L. & Anton, S. D. (2001). Individual versus group therapy for obesity: effects of matching participants to their treatment preferences [Electronic Version]. *Journal of Consulting and Clinical Psychology, 69*, 717-21.

Research, F. (2008). Weighing up the burden of obesity: a review by Dr Foster Research. London. Retrieved 2nd March from www.drfosterintelligence.co.uk/newsPublications/loclDocuments/WeightingUpTheBurdenOfObesityReport.pdf

Resnick, H.E., Valsania, P., Halter, J. B. & Lin, X. H. (1998). Differential effects of BMI on diabetes risk among black and white Americans [Electronic version]. *Diabetes Care, 21*, 1828-1835.

Ricoeur, P. (1976). *Interpretation theory: Discourse and the surplus of meaning*. Fort Worth, TX: Texas Christian University Press.

Robinson, M. & Cottrell, D. (2005). Health professionals in multi-disciplinary and multi-agency teams: Changing professional practice [Electronic version]. *Journal of Interprofessional Care, 19* (6), 547-560.

Rolfe, G. (2004). Methodological Issues in Nursing Research. Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing, 53* (3), 304-310.

Rossner, S. (1991). Factors determining the long-term outcome of obesity treatment. In P. Bjorntorp., & B.N. Brodoff (Ed.) *Obesity (pp. 712-719)*. Philadelphia: J.B. Lippincott Co.

Ryan, D. (1996). Medicating the obese patient [Electronic version]. *Endocrinology Metabolism Clinics of North America, 25*, 989 –1004.

Safron, M., Cislak, A., Gaspar, T. & Luszczynska, A. (2011). Effects of school- based interventions targeting obesity-related behaviours and body weight change: A systematic Umbrella Review [Electronic version]. *Behavioral Medicine, 37*, 15-25

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Science, 16* (2), 1-8.

Schvey, N., Puhl, R. & Brownell, K. (2011). The impact of weight stigma on caloric consumption [Electronic version]. *Obesity, 10*, 1957-62.

Schvey, N. A., Puhl, R. M. & Brownell, K. D. (2014). The Stress of Stigma: Exploring the Effect of Weight Stigma on Cortisol Reactivity [Electronic version]. *Psychosomatic Medicine, 76*, 1-7.

Schwartz, M. B., Chambliss, H. O., Brownell, K. D., Blair, S. N. & Billington, C. (2003). Weight Bias among Health Professionals Specializing in Obesity [Electronic version]. *Obesity Research, 11* (9), 1033-1039.

Seacat, J. D. & Mickelson, K. D. (2009). Stereotype threat and the exercise/dietary health intentions of overweight women [Electronic version]. *Journal of Health Psychology, 14*, 556-67.

Serdula, M. K., Mokdad, A. H., Williamson, D. F., Galuska, D, A., Mendlein, J. M. & Heath, G. W. (1999). Prevalence of Attempting Weight Loss and Strategies for Controlling Weight [Electronic version]. *Journal of the American Medical Association, 282,* 1353-1358.

Scott. J. G., Cohen. D., DiCicco-Bloom. B., Orzano. A. J., Gregory. P., Flocke. S. A., Maxwell. L. & Crabtree. B. (2004). Speaking of weight: How patients and primary care clinicians initiate weight loss counselling [Electronic version]. *Preventive Medicine, 38* (6), 819-827.

Shaw, K. A., O'Rourke, P., Del Mar, C. & Kenardy, J. (2009). Psychological interventions for overweight or obesity (Review) [Electronic version]. *The Cochrane Library, 2*, 1-75.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects [Electronic version]. *Education for Information, 22*, 63-75**.**

Sherbourne, C. D., Hays, R, D., Ordway, L., DiMatteo, M. R. & Kravitz, R. L. (1992). Antecedents of adherence to medical recommendations: Results from the medical outcomes study [Electronic version]. *Journal of Behavioural Medicine, 15* (5), 447-468.

Scottish Intercollegiate Guidelines Network. (2010). *Management of obesity: A national clinical guidance.* Edinburgh: SIGN.

Silverman, D. (Ed.) (2000). *Doing qualitative research: A practice handbook*. London: Sage.

Smith, J. A. (Ed.) (2003). *Qualitative psychology: a practical guide to research methods*. London: Sage.

Sockalingam, S., Wnuk, S., Strimas, R., Hawa, R. & Okrainec, A. (2011). The association between attachment avoidance and quality of life in bariatric surgery candidates [Electronic version]. *Obesity Facts, 4*, 456–460.

Strauss, A. (1987). *Qualitative analysis for social scientist*. New York: Cambridge University Press. Retrieved 14th April from www.books.google.co.uk/books?isbn=0521338069

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Streubert, H. J. & Carpenter, D. R. (Ed.) (2003). *Qualitative research in nursing: Advancing the humanistic imperative.* Philadelphia, PA: Lippincott, Williams & Wilkins. Retrieved 20th April from *www.books.google.co.uk/books?isbn=0781796008*

Teachman, B. A., Gapinski, K. D., Brownell, K. D., Rawlins, M. & Jeyaram, S. (2003). Demonstrations of implicit anti-fat bias: The impact of providing causal information and evoking empathy [Electronic version]. *Health Psychology, 22*, 68-78.

The British Association of Counselling and Psychotherapy BACP (2012). Retrieved 22nd April from www.bacp.co.uk/

The British Psychological Society (2005). *Division of Counselling Psychology Guidelines on professional practice guidelines.* Leicester: BPS.

The British Psychological Society (n.d.). *Careers: Counselling Psychology*. Retrieved 3rd May 2016 from http://careers.bps.org.uk/area/counselling

The British Psychological Society (2010). *Code of human research ethics*. Leicester: Author.

The Department of Health (2012). *The NHS and Social Care Act 2012*. Choice in health and Social Care and NHS efficiency.

The Scottish Government (2010). *Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight.* Edinburgh: The Scottish Government. Retrieved 12th April from www.scotland.gov.uk/Publications/2010/02/17140721/0.

The Working Group (2014). *The Joined up Clinical Pathways for Obesity: Report of the Working Group.* NHS England Publications Gateway.

Thomas, S. L., Hyde, J., Karunaratne, A., Kausman, R. & Komesaroff, P. A. (2008). "They all work…when you stick to them": A qualitative investigation of dieting, weight loss, and physical exercise, in obese individuals [Electronic version]. *Nutrition Journal, 7* (34), 1-7.

Trombint, E., Baldaro, B., Bertaccini, R., Mattei, C., Montebarocci, O. & Rossi, N. (2003). Maternal Attitudes and attachment styles in mothers of obese children [Electronic version]. *Perceptual and Motor Skills, 97* (2), 613-620.

Tuckett, A.G. (2005). Applying Thematic Analysis Theory to Practice: a researcher's experience [Electronic version]. *Contemporary Nurse, 19*, 75–87.

Van Manen, M. (1990). *Researching lived experience: Human Science for an action sensitive pedagogy.* London, Ontario: The University of Western Ontario. Retrieved 10th March from www.books.google.co.uk/books/about/Researching_Lived_Experience.html?id=fBCZ5n6okOYC

Vartanian, L. & Novak, S. (2010). Internalized societal attitudes moderate the impact of weight stigma on avoidance of exercise [Electronic version]. *Obesity, 19*, 757-62.

Wadden, T. A., Berkowitz, R. I., Womble, L. G., Sarwer, D. B., Phelan, S., Cato, R. K., Hesson, L. A., Osei, S. Y., Kaplan, R. & Stunkard, A. J. (2011). A two-year randomised trial of obesity treatment in primary care practice [Electronic version]. *New England Journal of Medicine, 365*, 1969-1979.

Wadden, T. A. & Butryn, M. L. (2003). Behavioral treatment of obesity [Electronic version]. *Endocrinology Metabolism Clinics of North America. 32* (4), 981-1003.

Wadden, T. A., Butryn, M. L. & Byrne, K. J. (2004). Efficacy of lifestyle modification for long-term weight control [Electronic version]. *Obesity Research, 12,* (S12), 151S-162S.

Wadden, T. A. & Foster, G. D. (1989). *Weight management guide*. Unpublished manuscript, University of Pennsylvania.

Wier, M. F. V., Ariens, G. A. M., Dekkers, J. C., Hendriksen, I. J. M., Smid, T. & Mechelen, W. V. (2009). Phone and email counselling are effective for weight management in an overweight working population: a randomised controlled trial [Electronic version]. *BioMed Central Public Health, 9*, 112-124.

Williams, G. C., Grow, V.M., Freedman, Z. R., Ryan, R. M. & Deci, E. L. (1996). Motivational Predictors of Weight Loss and Weight-Loss Maintenance [Electronic version]. *Journal of Personality and Social Psychology, 70* (1), 115-126.

Wing, R. R. (1995). *Pittsburgh behavioural weight control manual.* Unpublished manuscript, University of Pittsburgh.

Wing, R. R. (1999). Physical activity in the treatment of the adulthood overweight and obesity: current evidence and research issues [Electronic version]. *Medicine & Science in Sports & Exercise, 31* (11), S547-52.

Woolfe, R. (1990). 'Counselling Psychology in Britain: An idea whose time has come'. *The Psychologist, 3* (12), 531-535.

Woolfe, R., Strawbridge, S., Douglas, B. & Dryden, W. (Ed). (2010). *Handbook of Counselling Psychology*. Sage Publications Ltd.

World Health Organisation (2006). "BMI Classifications" www.who.int/bmi/index.jsp?introPage=intro_3.html

World Health Organisation. (2011). *World Health Statistics 2011.* World Health Statistical Information System (WHOSIS).

World Health Organisation (2015). *Obesity and Overweight.* Fact sheet No 311. Retrieved on 15th July www.who.int/mediacentre/factsheets/fs311/en/

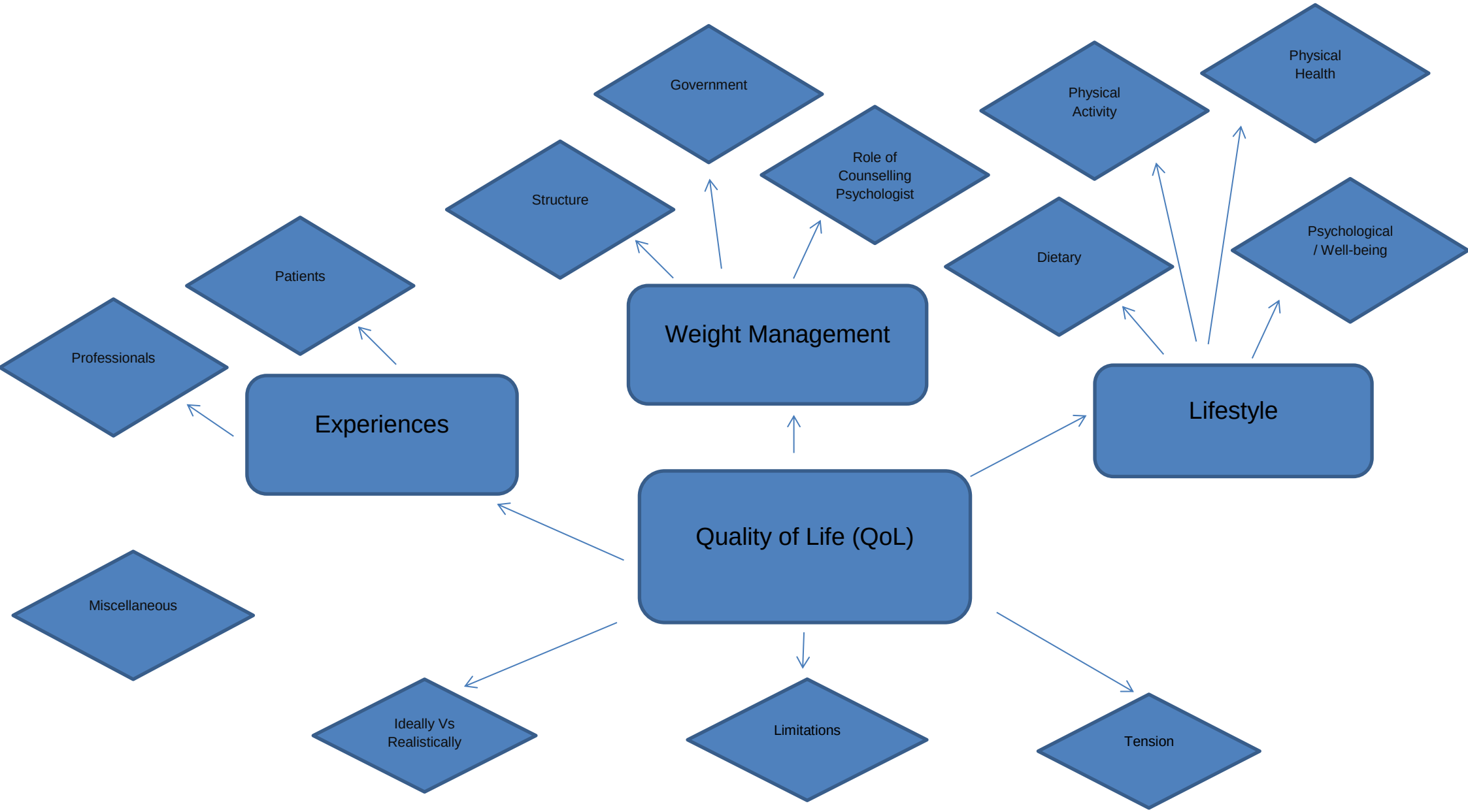
Yancey, A. T. (2007). Social Ecological Influences on Obesity Control: Instigating Problems and Informing Potential Solutions [Electronic version]. *Obesity Management, 3* (2), 74-79**.**

Zhang, Q. & Wang, Y. (2004). Socioeconomic inequality of obesity in the United States: do gender, age, and ethnicity matter? [Electronic version]. *Social Science and Medicine, 58* (6), 1171-1180.

Appendix A: Explanation and Diagram of themes

Diagram of Themes

Diagram 1



Explanation of 'Diagram of themes' to 'Tension in weight management' (final version)

Braun and Clarke's (2006) six phases were followed as below.

1. *Familiarisation with the data* included the researcher becoming familiar with the data and listening to and reading and re-reading the data (Braun and Clarke, 2006).

2. *Coding* included the researcher to code every data item and ended this phase by collating all the codes (Braun and Clarke, 2006), and relevant data extracts (please see document titled 'All Codes') where these codes included:

- Lifestyle (LF)
- Physical Health (H)
- Psychological / emotional well-being (Psyc)
- Weight Loss (WL)
- Info on WM (I)
- Factors support WL (WL)
- Quality of Life (QoL)
- Professional / patient Experience (PE)
- Structure for the WM programme (S)

- Medical (M)
- Role of Counselling Psychologist (RoP)
- Societal (So)
- Misc (M)

A working example of the QoL theme

3. *Searching for themes* was similar to coding the codes to identify similarity in the data. This is an active process; where themes are not hidden in the data waiting to be discovered. The researcher constructed these themes and ended this phase by collating all the coded data relevant to each theme (Braun and Clarke, 2006). For example, reflecting on how the QoL main theme came to consist of two sub-themes: 'Ideal' and 'Actual'. Below is an example, of how the sub-theme 'Ideal' had evolved and became an important part of the findings.

Transcript data	Name of Respondent	Potential Codes
'the motivation has to be at the right mind-set' (L98), 'ready to engage' (L106), 'looking at self-esteem and how people feel about themselves', 'looking at their	Amy (Professional)	Psyc, PE and RoP.

mood' (L113-114). --- *'changing that sort've perception 'n' trying to put things in place so that rather than using food as an emotional support' (L154-156), 'a lot of focus 'n' effort' (L161), 'lifestyle modification' (L165), 'motivation is a big factor' (L169).*	--- Dave (Professional)	--- WL, QoL, LF, Psyc.
' determination', 'open-minded' (L149), 'willing to change' (L151), 'willing to able to plan' (L154), and 'willing to make those changes' (L156-7).	Diane (Professional)	Psyc, RoP, WL and PE.
'if I was healthy and (what was the original question quality of life was it?) I mean if you've got full health, then then obviously the world's your oyster isn't it? You're in	Gill (Patient)	H, WL, LF, QoL, Psyc.

control of your own life and you can do what you want to do can't you? So if say the ME wasn't a difficulty for you, what would you perceive as your quality of life? What sort of factors would kind of count? What would count as part of your quality of life? What helps make life better? Just sort of general feeling of well-being and contentness. And how would you achieve that? and not being over-whelmed 'cos I think the thing I always sort of feel is I'm drowning all the time because there's always something to be done that's important and not enough energy to do it so if I was content with life, it would be just that you would be kind of coping, I guess.		

And thinking about that practically, how would that play out in your life? Well, you'd be working, you'd have money, you'd be having fun, you'd be exercising, you'd be eating healthily, you'd be erm going on holiday and all sorts of nice things like that and actually sleeping which is something that is a problem with ME people as well, 'cos you don't have refreshing sleeps, so you wake up feeling as bad as when you've gone to bed, so it would be nice!' (L279-295).		
---	---	---
'being able to do the things I like doing you know Not feeling down and negative about everything. You know and just basically	Bob (Patient)	QoL, Psyc, RoP.

enjoying life not feeling down and negative about everything. You know and just basically enjoying life' (L965-967).		

Table 1

It was apparent in table 1 that there was an overlap of the codes being identified from the raw data. This content of the transcript data focused upon the type of quality of life patients would like to ideally have or professionals would like to have for their clients.

Below in table 2 is an example, of how the sub-theme 'actual' had evolved and became an important part of the findings.

Transcript data	**Name of Respondent**	**Potential Codes**
'if I can see depression there, or causing them to overeat for example, you know that's causing them depression, the eating might go hand in hand with that one so that's something to look at' (L115-118).	Amy (Professional)	Psyc, I, QoL.
----------	----------	----------
'education' (L141), 'family traits so if 'em	Dave (Professional)	LF, QoL, WL, Psyc, PE.

if the family ave *always been big eaters' (L144) 'they find it hard to break the cycle' (L145), and 'sometimes partners* 'n' they as well err quite difficult cuz some of them *are sort've feeders' (L146-147).* *'You know what their motivations are what their targets are 'n' what their chances are where in some of the people who we see they obviously got mobility issues, multiple co-morbidities you know even if they made food changes* n' try 'n' improve things that *you think it's going to be hard for them' (L190-194).*		Psyc, RoP, WL, H, QoL.
'I've got to try and make the most of what I have got so I do try and do the positive you know even if it's only looking at a nice	Gill (patient)	Psyc, QoL, WL, H.

blue sky or a nice cup of tea or whatever it may be, so I have to try and make my kind of world goals pretty darn small' (L275-278). *'Well I've had to lower my standards so basically it's surviving the day' (L297)*		
'I need to maintain pain problems to be honest' (L976-977) 'if I can get up on a daily basis and pain's not too bad and I'm able to manage it painkillers whatever, generally I can have a good day you know I mean I'd be positive. I can't do everything I want to do' (L999-1001).	Bob (patient)	H, Psyc, QoL, LF, RoP.
'being able to walk out into the country' (L552), 'We caravan a lot, erm, we go off	Barbara (patient)	QoL, LF, Psyc, PE.

in that, for a month at a time if we want to' (L556-557).		

Table 2

4. *Reviewing themes* involved checking that the themes 'worked' in relation to both the coded extracts and the full data-set. It could be necessary to collapse two themes together or to split a theme into two or more themes, or to discard the original themes altogether and re-start the process of theme development again (Braun and Clarke, 2006). This initially led to the sub-theme being titled 'ideally' as shown in diagram 1. Although in diagram 1 it has also been named with 'realistically'. With further codes leading to the sub-themes emerging from the data it was deemed suitable to re-name this sub-theme to 'desired Vs actual', as reflected in diagram 2.

5. *Defining and naming themes* required the researcher to identify the 'essence' of each theme and construct a concise, punchy and informative name for each theme (Braun and Clarke, 2006). After extensive discussions with the supervisory team and putting all main and sub-themes together concisely it was then agreed that this sub-theme was more reflective of the data by splitting the subtheme into two and naming them 'ideal' and 'actual' accounts (reflected in diagram 3) of individuals quality of life, whether this was as the patient or the professionals viewpoint.

6. *Writing up* involved weaving together the analytic narrative and data extracts to present a coherent and persuasive story about the data, and contextualising it in relation to existing literature (Braun and Clarke, 2006), which is reflected in the thesis; Chapter 3 Results and Discussion and Chapter 4 the Overall Discussion. Therefore these two sub-themes were presented as better placed under the main theme of 'Quality of Life' (QoL), which was the common theme emerging from these sub-themes, as shown in tables 1 and 2, as well as mentioned in diagram 3.

Overview of how some of the other sub-themes and main themes emerged.

The same process of Braun and Clarke's (2006) six phases was applied (as discussed above) to the process of formation for all the sub and main themes for this study, more so phases 4 and 5 are repeatedly utilised in this section below to reach the final version of the themes reflected in Diagram 3.

- The codes in 'medical' were the same as those in 'physical health'. Therefore, with further refining it was appropriate to label this theme 'physical health' and that it was well placed under the main theme of 'Lifestyle'. An example of merging two themes was 'Factors supporting WL' was incorporated in to 'Lifestyle' as the codes were the same and the latter theme name seemed more appropriate and eventually became a main theme. 'Misc' was eventually removed as there were no

codes that needed to be kept in this theme as they all seemed to better placed under other sub-themes. This was illustrated in Diagram 1.

- Whilst re-visiting the data to ensure no significant codes, leading to sub and or main themes had been overlooked, it became apparent that what had been given less importance at this stage was the sub-theme ‘tension’. This sub-theme was an integral central theme that was a lot more important in the data than originally identified. ‘Tension’ was then shifted to the centre of the diagram and given the most importance, making it a central theme in ‘Tensions in weight management interventions’ in diagram 2.
- In the ‘tensions in weight management interventions’ diagram 2, there were five main themes including ‘desired V’s actual’ weight. Whilst refining the codes and themes this was re-visited as part of good practice. Initially this theme seemed apparent across all the data, but when the data was re-visited again it was decided that it was a sub-theme that was well placed under the QoL theme. The defining and naming themes resulted in the final version of ‘tensions in weight management interventions’ diagram 3.

Tensions in weight management interventions

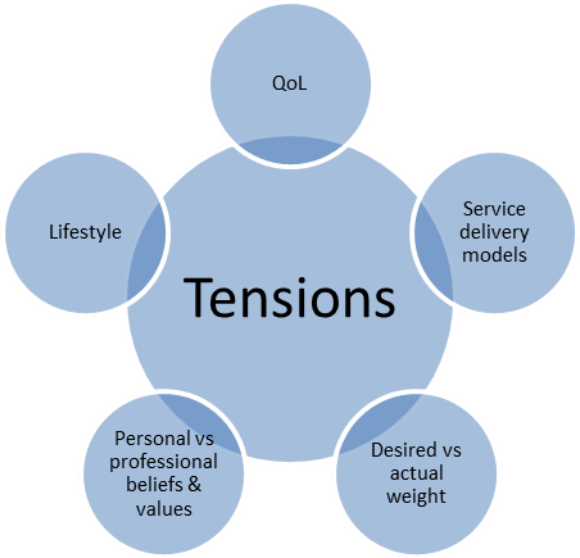


Diagram 2

Tensions in weight management interventions (final version)

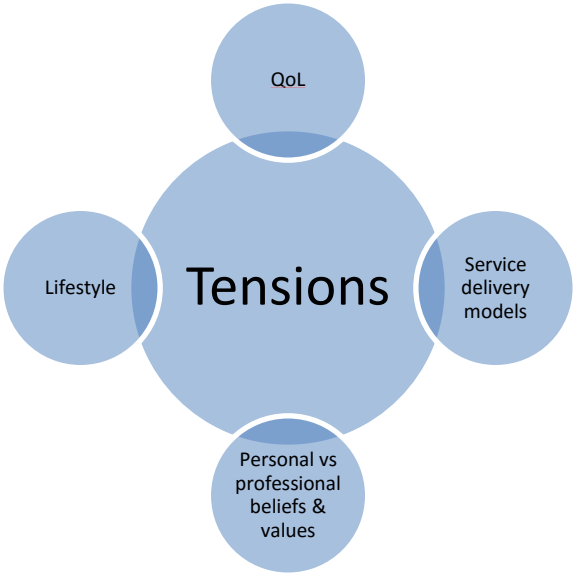


Diagram 3